

Financial Resource Flows for Population Activities

Report of a case study in Peru

The views expressed in this report are those of the mission and not necessarily those of the United Nations Population Fund.

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Preface

In the Program of Action, adopted at the International Conference on Population and Development (ICPD) in Cairo on 5-13 September 1994, countries have committed themselves to attain specific goals in the field of population and sustainable development. Measuring financial resources, which countries commit to population activities is an important way to monitor the progress of the implementation of the Program of Action of the ICPD.

UNFPA is collaborating with the Netherlands Interdisciplinary Demographic Institute (NIDI) to develop and maintain an updated system for the collection, analysis and dissemination of information on both international and domestic financial resource flows for population activities.

The classification of population activities in this study closely reflects the principles of the ICPD. For operational reasons, it was decided to restrict data collection to the 'ICPD costed package' mentioned in paragraph 13.14 of the Program of Action. This means four categories of population activities:¹

- family planning services;
- reproductive health services;
- STD and HIV/AIDS programs;
- basic research, data and population and development policy analysis.

¹ Basic reproductive health services given at primary health care level include: Information and routine services for prenatal care, normal and safe delivery, post-natal care; abortion (as specified in paragraph 8.25 of the ICPD document); information, education and communication (IEC) about reproductive health, human sexuality and responsible parenthood, and against harmful practices; adequate counselling; diagnosis and treatment for reproductive tract infections, as feasible; prevention of infertility and appropriate treatment, where feasible; and referrals, education and counselling services for pregnancy and delivery complications.

In paragraph 13.15 of the same document, it is estimated that, in developing countries and countries with economies in transition, the implementation of programs in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases, as well as other basic actions for collecting and analyzing population data will cost \$ 17.0 billion in 2000, and increase to \$ 21.7 billion in 2015. Two-third should be paid by the recipient countries, one-third by the international donor community.

In order to measure global financial resource flows for population activities, the UNFPA/NIDI Resource Flows project has sent questionnaires in 1998 to public and private donor organizations in developed countries, and to government departments and national NGOs in developing countries and countries in transition. Collecting all this information from a broad range of respondents is not without problems in terms of issues of definitions, classifications, response rates and time lines. To better understand and resolve these problems, country case studies are conducted. These case studies will complement our knowledge about financial flows for population activities which was obtained through the mail enquiry.

The case study in Peru was conducted from 28/10/1999 to 17/11/1999, and forms part of the UNFPA-NIDI project, which measures global financial resource flows for population activities. Data for this report were gathered by Mr. Ernest Spaan and Ms. Mik van de Klundert, staff members of the UNFPA/NIDI Resource Flows Team, together with Ms. Anne-Laure Pochat, a development consultant based in Lima. Mr. Rogelio Fernandez-Castilla, UNFPA Representative for Peru, and his staff provided valuable help and advice.

We like to extend our sincere gratitude to Mr. Rogelio Fernandez-Castilla, Mr. Diego Palacios and the other UNFPA staff in Lima, for the warm welcome and providing the necessary logistic support for this case study. Many thanks are due to the respondents, who kindly shared their time and information with us.

Currently, the public health sector of Peru is under reform, including the decentralization of planning and financial management. This state of affairs, together with the short duration of this study, has made the measuring of resource flows for reproductive health and population less straightforward, so that this report could contain some omissions and inaccuracies. However, the authors have striven at comprehensiveness and accuracy. They take full responsibility for any errors and welcome any comments and suggestions for the improvement of this report.

Ernst Spaan, Mik van de Klundert and Anne-Laure Pochat

February 2000

1. Demography of Peru

Peru is ranked as an upper-middle-income country, and is currently recovering from the political, social and economic crisis of the 1980s and early 1990s. The government of President Fujimori took office in July 1990 and introduced a market-oriented economic policy characterized by structural adjustment, austerity measures and privatization of major economic sectors. In 1998 the Peruvian economy suffered from the effects of the El Niño phenomenon, resulting in an estimated reduction in GDP of three per cent due to losses in output and income of the agricultural and fishery sectors (IADB, 1999). Furthermore, the negative effects of the Asian financial crisis were also felt in Peru.

The GNP per capita was US\$ 920 per capita in the late 1980's and increased to US\$ 2,460 in 1998, which is above the average for the lower-middle income group countries (US\$ 1,557). The GNP has shown an average annual growth of 2.6 in the period 1988-1998 (World Bank, 1999). However, the aggregate socio-economic indicators hide the sharp contrasts in income, wealth and health indicators between the urban and rural populations, and between the coastal (*costa*), Andean (*sierra*) and Amazon (*selva*) regions. The coastal region occupies about 11 per cent of Peru total land area, while that percentage is 32 per cent and 57 per cent for the sierra and selva regions respectively. Moreover, access to health services varies greatly by regional, ethnic and income groups. The relatively isolated population groups in the mountains and Amazon forests are the most deprived group in this regard. Administratively, Peru is divided into 24 departments (plus Callao), 194 provinces and 1812 districts (DHS, 1996).

Peru's population stood at 25,2 million persons in 1999, up from 21,6 million in 1990 and 23,5 million in 1995 (INEI, 1999), of which 72 per cent lived in urban areas. The average population growth rate for Peru in the period 1995-2000 was 1.7 per cent per annum, down from 2.0 in the 1981-1993 period. In terms of age distribution of the population aged 15-64 years has increased from 55 per cent in

1981 to 61 per cent in 1999, while the youngest age group (0-14 years) decreased from 42 per cent in 1981 to 34 per cent in 1999.

The population is unevenly distributed across the country. In 1990 about 69 per cent of the total population lived in an urban area. The share of the urban population grew to 71 per cent in 1995 and further to 72 per cent in 1999 (PROMUDEH, 1999; INEI, 1999). Metropolitan Lima alone accounted for 29.1 per cent of the total population in 1999, or 7,331,300 people. Lima remains the main pole of attraction for migrants from the rural areas. The population distribution in 1999 by natural regions is as follows: *costa* (53 per cent), *sierra* (37.2 per cent) and *selva* (9.8 per cent) (INEI, 1999). The coastal region contains most urban centers and is the most accessible part of the country, which has implications for the distribution of health services. In many respects the population of the *sierra* and *selva* regions are most deprived, although large differences in wealth and welfare indicators are discernible within each region.

Table 1.1 provides some recent demographic indicators for Peru as a whole, together with the target indicators of the ICPD Program of Action. Although *Table 1.1* shows that progress has been made in terms of reproductive health indicators since the 1980s, the figures mask considerable discrepancies between the different regions within the country.

Table 1.1. Target indicators and achievements for the ICPD PoA

Target indicators and achievements for ICPD, Peru			
Indicator	Pre-ICPD	1996	ICPD target
MMR (per 100,000 life births)	261	265	<100
	1991	1990-1996	
IMR (per 1,000 life births)	64	50	<50
	1991		
IMR indigenous population Amazonia	112	N.a.	<50
	1993		
Under five mortality per 1,000 births	78	59	<60
	1991		
Life expectancy	65,6	68,5	>70
	1990	1998	
CPR (women 15-44 years)	59%	64%	>55%
	1991		
Births attended by trained staff	52.5%	56.4%	>60%
Female school enrolment primary level	86.8%	94.2%	>75%
	1993	1998	
Female literacy	81.7%	84.4%	>50%

Source: Peru: Informe Nacional sobre la Implementación del Programa de Acción del Cairo, Lima: PROMUDEH, 1999.

In general, Peru has made good progress in health and education during the last decade. The illiteracy level has been brought down from 18 per cent in 1981, to 13 per cent in 1993 and 10.5 per cent in 1996 and the female school enrollment at primary level has increased to a high 94 per cent in 1996 (Presidencia de la República, 1998). Illiteracy has decreased between 1993-1996: from 18 to 15.5 per cent for women and from 7 to 5 per cent for men. Life expectancy at birth has increased from 66 years in 1990 to 69 years in 1999. For men the figures are 63,2 (1990) and 66,3 (1999) and for women 68 (1990) and 71,3 (1999).

Although there is an urban bias, during the last few years the coverage of health services has improved in rural areas. Since 1994, the number of health posts has increased from 600 to over 3000, among which many newly established ones in remote *sierra* and *selva* areas. Currently, a major problem is the under-utilization of the health services, especially in the rural areas. Factors responsible for this are geographical distance, logistic problems, cultural differences, and a preference for traditional methods and health practitioners (e.g. TBAs). The past problems with surgical contraception have made many people distrustful of

public sector services. Currently, the Peruvian government is addressing these issues.

The infant mortality rate per 1,000 live births decreased from 55 in 1991 to 50 in 1996 (INEI, ENDES, 1991/92, 1996). The IMR is higher for the rural compared to the urban areas however. In 1991 the IMR was 40 against 78 for urban and rural areas respectively, which decreased to 30 and 62 in 1996. A report by UNICEF reported much higher figures for the indigenous population of Amazonia: the IMR for 1993 in the 12 communities studied, varied from 99 to 153. In 1999 the IMR was estimated at 42,5; this was 33,1 in urban and 55,0 in rural areas (INEI, 1999).

Maternal mortality is still a serious problem in Peru, and is currently one of the priority areas for intervention of the government and NGOs. The maternal mortality rate (MMR) has even *increased* during the last decade and remains far removed from the ICPD target. In 1991/92, maternal mortality stood at 261 deaths per 100,000 live births but the 1996 DHS estimated it even higher at 265 (ENDES, 1996). The main causes of maternal mortality in Peru are unsafe abortions, haemorrhage, reproductive tract infections and pre-eclampsia (Vásquez Pérez, 1996). The number of births attended by trained health staff (doctors, obstetricians, midwives) has increased since the ICPD from 52,5 to 56,4 per cent. This is still below the target of at least 60 per cent of all deliveries. Again, there are significant discrepancies between urban and rural areas and regions of the country.

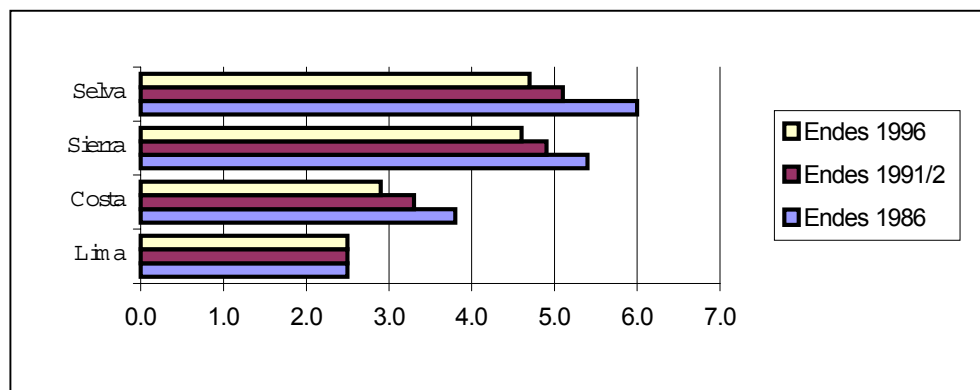
The total fertility rate (TFR) for Peru has shown a declining trend since the 1960s. It declined from 6.8 in 1965 to 6.0 in 1975 and declined further to 4.0 in 1985. During the 1990s this downward trend continued. The TFR for Peru was 3.4 in 1993 and 3.5 in 1996. However, it should be noted that the TFR varies considerably across the different departments of the country, corresponding with levels of accessibility, poverty, level of education and access to health services in general.

Figure 1.1 shows the trend in TFR for the major geographical regions of Peru and metropolitan Lima. The highest TFR in 1996 were recorded in the departments in the *sierra* and *selva* regions Huancavelica (6.5), Apurimac (5.9), Huanuco (4.9), Pasco (4.9), Amazonas (5.0) and Loreto (4.8). This contrasts with the coastal regions with lower TFRs: Arequipa (3.3), Ica (2.8), Lima (2.6),

La Libertad (3.8) and Lambayeque (3.6) (ENDES III, *Encuesta Nacional de Salud Familiar*, 1996).

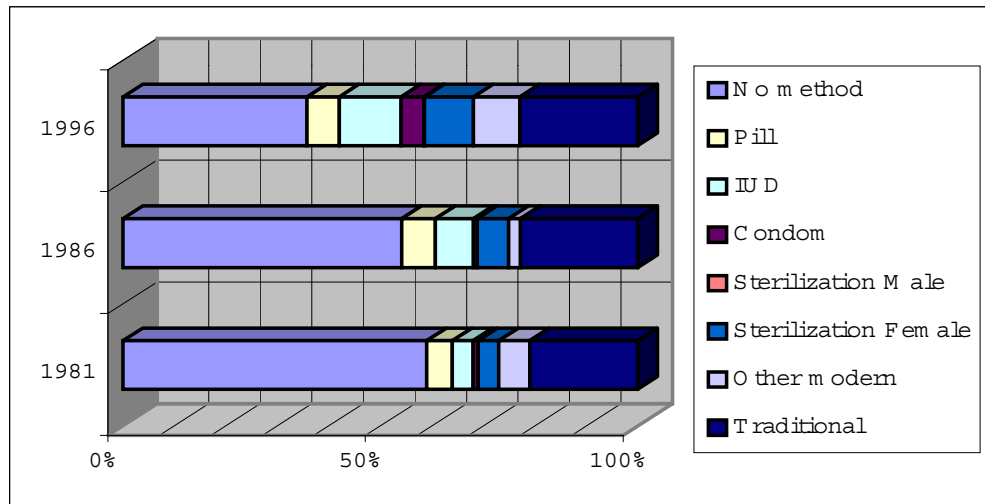
The decline in fertility is in large part due to the increase in the use of contraceptives (*Figure 1.2*). The contraceptive prevalence rate (CPR) increased from 57 per cent in 1990 to 68 per cent in 1998. The use of modern methods increased from 31 per cent in 1990 to 42 per cent in 1998 (INEL, 1999). The main modern methods used in 1996 were IUD's, female sterilization and injectables. The number of users of the latter method has been growing since 1995. Even so, the unmet need for family planning among married women aged 15 to 49 years was 12 per cent in 1996, i.e. 9 per cent for limiting births and 3 per cent for spacing (DHS, 1996). This too varies by geographical region, from 9 per cent for the coast, 17 per cent in the *sierra* to 15 per cent in the *selva*. In Metropolitan Lima it was almost 8 per cent (DHS, 1996).

Figure 1.1. TFR by major geographical regions, Peru, 1986, 1991, 1996



Source: Encuesta Demográfica y de Salud Familiar (ENDES, DHS), 1986, 1991/2 and 1996.

Figure 1.2. Peru, Contraceptive method mix, 1981-1996



Source: McDevitt, US Bureau of the Census 1999 (based on DHS data).

One consequence of the unmet need is the high number of unwanted pregnancies, which in many cases are terminated by abortion. Abortion is illegal in Peru, except when a woman's health or life is in danger. A report of the Peruvian Society for Obstetrics and Gynaecology (SPOG, 1999) estimated that 60 per cent of all pregnancies in Peru are unwanted (based on data from the Alan Guttmacher Institute, 1997). Of these, half will lead to unwanted births and the other half will end in induced abortion. The same report estimated a total of 324,000 abortions in 1997, which related to live births, is the equivalent of 46 abortions for every 100 births. Unsafe abortion is the second leading cause of maternal mortality in Peru.

The HIV/AIDS epidemic has not hit Peru as hard as other countries yet, in particular those in Africa. However, the number of people carrying the HIV virus or having AIDS is on the increase: since 1983, when the first HIV infected person was registered, up to June 1999, 17,191 people have tested positive for HIV and 8,742 people were reported suffering from AIDS. The HIV prevalence was 0,2 per cent at that date. These figures concern registered cases so that the real numbers are probably much higher. The great majority of registered cases

were recorded in the urban areas of Lima (63.5 per cent), Callao (8.4 per cent) and Ica (5.8 per cent) (PROCETSS, 1999, datasheet). The modes of transmission are mainly through sexual relations (94 per cent), followed by blood contact (4 per cent). Perinatal transmission only accounted for two per cent of cases (PROCETSS, in Guevara, 1996).

Although Peru has made progress in tackling rural and urban poverty and improving the health condition of its population in the last decade, many problems still remain. There are still many under-served communities in the mountain and Amazon regions, as well as in the urban periphery. In general, there is still a large imbalance in basic social services between the rural and urban areas and between the coastal and other regions within Peru. Important reproductive health problems still exist such as the high maternal mortality rates, unwanted teenage pregnancies and unsafe abortion.

2. Methodological issues

The specific objectives of the case study in Peru are:

- to fine-tune and refine data collection procedures for estimating financial resource flows for population activities. These procedures can be used at a later stage in the global mail enquiry;
- as benchmarks for studying the quality of data gathered through the mail enquiry in other countries;
- to gather more information on financial sources in relation to the implementation of the Program of Action of the ICPD: are there any changes in priority at the government or at the donors' level; has the ICPD Plan of Action influenced the population policy and programs within the country? And how?
- to provide more information on how resource flows are directed towards population activities within the country and, how the ICPD Program of Action is implemented;
- to investigate the roles of government agencies and NGOs in the field of population activities;
- to study possible methods for sustainability used within the country: e.g. cost recovery in public programs;
- to study co-ordination between and among government departments, NGOs and donors.

Next to geographical considerations, Peru was chosen as a case study for the following reasons: it is one of the poorest countries in Latin America and is currently undergoing rapid political and socioeconomic change. Furthermore, the health system is under reform, with important implications for the implementation of population policy on the one hand and the measurement of resource flows on the other.

From 28/10/98 to 17/11/99 interviews were held with representatives from government agencies, international donors (bilateral, multilateral), national and

international NGOs and private companies in Lima. Annex 1 provides a list of all persons and organizations contacted during the case study. In general, the respondents were very cooperative and shared their information without any reluctance.

To optimize the quality of the information, the team followed as much as possible a standard strategy:

- data were collected through the questionnaires;
- questionnaires were checked for quality and consistency;
- during the interviews with representatives from the organizations covered in the survey, inconsistencies in the data were clarified;
- if necessary information was corrected; in some cases a second visit was made to the organization;
- written documentation or information on the internet about activities and the organization's budgets were collected, if possible;
- in-depth oral information was gathered about various activities of the organization such as: historical overview of funding, implementation of the ICPD Program of Action, past and current priorities, future plans and activities, future financial outlook, co-operation and co-ordination with other NGOs or government agencies, donors *et cetera*.

As Peru is reforming and decentralizing its health system special attention was paid to the implications of this process for tracking resource flows. The team is confident that the information obtained in the case study is of good quality. The fact that many of the organizations provided audited financial overviews for several years (some as far back as 1990) has certainly improved the quality of the data. In many cases respondents had to invest considerable amounts of time and effort to come up with exact figures on financial aspects of their operation.

Shortcomings

During the case studies it became clear that some aspects of the data collection pose some problems and that there is still further room for improvement in the coming years. Within the Resource Flows project the population categories as defined in paragraph 13.14 of the ICPD 'Program of Action' (United Nations, ICPD 94) are used. An important problem is formed by the fact that the four population activity groups, which are used to categorize financial flows, are often not used by the organizations concerned as budget lines. Moreover, the categories are not completely mutually exclusive. Especially the lines between

reproductive health, family planning and sometimes HIV/AIDS prevention activities are not always obvious. For instance, a condom distribution program could easily be seen as a family planning or HIV/AIDS prevention program. Equally, a project to promote longer periods of breast-feeding can be seen as a reproductive health activity, but equally has a natural family-planning dimension. Many organizations do not distinguish between family planning and reproductive health but use one category for their budget-line instead.

Other complications are:

- indirect national expenditures on staff, housing, utilities and so forth are sometimes ignored, as well as other indirect financial mechanisms like e.g. television and radio broadcasting time for messages on population and family planning;
- in the case of government departments and agencies, working at provincial and district level, overheads such as salaries are sometimes included in the budgets of another Ministry;
- the complexity of the funding of government health and family planning services, make it difficult to estimate exact expenditure figures. Exact figures on regional and district level expenditures could not be obtained because only aggregate figures for health were available at the central government agencies;
- because the government health system is under reform, and its information systems are under revision or inadequate for the tracking of resource flows for population activities, the requested information was often difficult to obtain. Some government departments or organizations could only provide allocations or global project budgets;
- due to the short duration of this study, a selection of organizations and government agencies to be visited had to be made, so that this report does not provide an exhaustive overview of all agencies active in population and reproductive health. However, the main actors have been included.

3. Official population policy and programs

3.1 | Government population policy

In 1980 the Peruvian government created the National Population Council (*Consejo Nacional de Población*, CONAPO). Between 1982-1996 CONAPO co-ordinated and planned population activities and family planning. It also aimed at promoting the active participation of NGOs, universities and donors in the population programs. In 1996 the functions of CONAPO were transferred to the newly established Ministry for the Promotion of Women and Human Development (*Ministerio de Promoción de la Mujer y del Desarrollo Humano*, PROMUDEH).

Family planning services became firmly established within the Ministry of Health (MINSA) in the early 1980's. However, at the time the coverage of public sector family planning services was still limited and most users obtained contraceptives from the private sector (in 1981 64 per cent of users). In 1985 the Peruvian government promulgated the National Law on Population (*Ley Nacional de Población*) which was an important initial step in the integration of population issues in official development policy. The law codified human rights and recognized the right of women to determine the desired number of children. Family planning and modern contraceptives were deemed acceptable but under the influence of the Catholic Church, the law still excluded abortion and surgical sterilization as forms of contraception. In this period, government policy was still aimed at fertility reduction through programs for the distribution of

contraceptives.² During the 1985-1990 period, president Garcia vowed support to a national family planning program. Initially, the program was ineffective due to the economic crisis and capacity problems. With the help of external funding (USAID, UNFPA) the public family planning services improved; the DHS survey of 1991/92 indicated a coverage of 48 per cent, up from 32 per cent in 1981.

Under the government of President of Fujimori (since July 1990) population matters have become an integral part of development policy. Reproductive health, family planning, juvenile unwanted pregnancies, promotion of women rights and sexual education is being incorporated in the poverty eradication and development plans. Government policy recognizes the fact that population welfare is related with employment, nutrition, illiteracy, low social status of women and limited access to (reproductive) health services. This influences demographic factors such as the infant mortality rate, maternal mortality and fertility rates. Within this context the Fujimori government has developed specific population plans, established special government agencies that implement programs and promulgated several laws in this field.

In 1991 a multi-sectoral committee was established to devise a national population plan, as a follow-up to the former one (1987-1990). The National Population Program 1991-1995 recognized the importance of reproductive rights, free choice in contraceptive use and the promotion of the equal participation of women in the socio-economic development. Some of the objectives of the program were the reduction of the natural growth rate of the population at two per cent per year, a TFR of 3.3 by 1995 and the decrease of maternal and perinatal mortality as well as unwanted pregnancies. Other objectives of the program are:

- The decrease of STDs;
- Improvement of services concerning infertility and gynaecological cancers;
- Promotion of the equal participation of women;
- Improvement of information and education on reproductive health;

² Through the Ministry of Health (MINSA), the Peruvian Institute of Social Security (IPSS) and the health programs of the Army and Police Forces.

- Promotion of IEC on reproductive health and HIV/AIDS for youth and women;
- Decentralization of the population policy and programs.

A new law on decentralization (*Ley de Descentralización*) stipulated the development of *Consejos Regionales de Población* (COREPOS), which are responsible for the co-ordination of population matters at lower administrative levels. The COREPOS are presided by the *Presidencia del Consejo Transitorio de Administración Regional* (CTAR) at central level and collaborate with the regional directorates of the Ministry of Health, Ministry of Education and the National Institute of Statistics and Informatics.

One of the problems of the Peruvian health system are the discrepancies between health services consumption of the poor and non-poor, the inefficiency and low productivity of PHC services and an insufficient adaptation to local needs (World Bank, 1999). To foster the coverage, efficiency and quality of health services in addition to more community participation at PHC level, the government initiated the *Programa de Administración Compartida* (PAC) in 1994. To facilitate the process, local shared administration committees (*Comités de Administración Compartida* or CLAS) have been established in the same year. The CLAS are local committees consisting of community representatives and the director of the local health facility. They are responsible for the administering of local-level public health facilities, overseeing the purchase of equipment and supplies and the preparation and implementation of local health programs (*Programa de Salud Local, PLS*). MINSA provides guidance and monitors the process. The funding comes from the central treasury through the Ministry of Health (Cortez, 1998). According to a World Bank study, the CLAS are successful in increasing the effectiveness of PHC in the ten per cent of MINSA clinics they operate (World Bank, 1999). In 1998 there were 548 CLAS in Peru covering 26 (sub)regions and almost three million persons. Over 60 per cent of CLAS are situated in poor regions of the country (Cortez, 1998). In November 1999 the number of CLAS had reached 900.

In general, between 1994 and 1997 the coverage of health services has increased: for public sector establishments from 16 per cent to 25 per cent and the private sector from six to eight percent (PAHO, 1998). In 1994, the Basic Health for All Program, coordinated by the Ministry of Health and funded from the Treasury, was launched.

Since 1995 the government has started to reform the health sector. The general objectives are an expansion of coverage, especially to the poor population; a more efficient use of resources and an increased effectiveness of interventions. The Health Policy Guidelines 1995-2000 defined the principles of the sectoral reform:

- Universal access to health care;
- Modernization of the health sector;
- Restructuring of the financing, services provision and control functions;
- Prioritizing the prevention and control of main health problems;
- Promotion of health lifestyles and conditions.

In 1995 the Peruvian government amended the 1985 law on population by including male and female sterilization as an acceptable family planning method to be provided by public services. The number of male sterilizations remains small in comparison to female sterilization.³ Female sterilization became a very sensitive issue on the part of the Church and women's NGOs, particularly after the controversy over alleged forced sterilization of rural and indigenous women (CLADEM, 1998). Abortion has remained an illegal practice however. These amendments formed the initial step in the formulation of a new family planning program. The government also embarked on a process of health reform including the decentralization of health services.

The legal framework for the health sector is laid down in the General Health Law (LGS) and the Law on the Modernization of Social Security (LMSS), both promulgated in 1995. The LMSS introduced new forms of health services, for those under the *Instituto Peruano de Seguro Social* (IPSS/ ESSALUD) involving the private sector.

In February 1996 the government adopted the National Program of Reproductive Health and Family Planning 1996-2000 (*Programa de Salud Reproductiva y Planificación Familiar 1996-2000*). The general aim of the program is to improve the reproductive health of Peruvian men and women through the provision of high-quality reproductive health services. It encompasses adolescent health, maternal-perinatal health, fertility control,

³ One source reports that out of 110,000 recorded sterilizations in 1997, only 9 per cent were male sterilizations (WEDO 1999).

prevention of gynaecological cancers, infertility treatment, prevention of STDs and HIV/AIDS. More specific targets are the decrease of maternal mortality to below 100 per 100,000 live births; a TFR of 2.5 by way of the extension of modern contraception to 50 per cent of fertile women (PROMUDEH, 1999; Susanibar, 1996). In addition the government aims at a reduction of the infant mortality rate to 34 per 1,000 live births by the year 2000 (MINSAs, 1996). The plan also stipulates more attention to informing clients on contraceptive choice, a minimum of 72 hours between consent and surgical operations and postoperative follow-up. The participation of different local NGOs and universities was envisaged. In 1998, the program was reformulated by the Ministry of Health, by which the family planning targets were removed.

In light of the pervasive high maternal mortality rates, the government has launched an emergency plan to reduce maternal mortality in 1998. Its aim is to increase the coverage of reproductive health services; improving the quality of services, with priority for emergency obstetric care; establishing client centered maternal/perinatal care; improved client-based IEC, safe motherhood; the development of local self-sustainable maternal-perinatal services and an adequate monitoring system for prevention of maternal mortality (MINSAs, 1998). Some more specific targets are:

- the reduction of the MMR to 100 per 100,000;
- a 50 per cent reduction of the perinatal mortality recorded in 1996;
- the increase of institutional coverage of prenatal care to 75 per cent, with at least four prenatal visits;
- to increase the percentage of births attended by trained health staff to 75 per cent;
- to increase the coverage of adequate maternal-perinatal care to 70 per cent of PHC units, including emergency obstetric care;
- to set up national IEC programs on sexual and reproductive health (in collaboration with the *Programa de Salud del Escolar y del Adolescente*) with a coverage of at least 60 per cent of all adolescents.

In 1998 the National Population Plan 1998-2002 was published by the Presidential Office, which outlines the basic principles, objectives, responsibilities, institutional actors and strategies to be followed in the new population policy. The program does not represent a major breach with the past population program, but now clearly reflects the perspectives and principles of the ICPD Program of Action. The objectives of the program are the integration

of population matters in the national, regional and local development programs, gender equity, improvement of (reproductive) health services and promotion of IEC for school youth and adolescents. Within COORDIPLAN (see next section), several ministries and government agencies are involved in the execution of the program such as the Ministry of Health, the Ministry for the Promotion of Women and Human Development, Ministry of Education, Ministry of the Presidency and the National Institute for Statistics and Informatics (INEI).

The Fujimori government aims at decentralizing the health services in the near future, implicating the devolving of responsibility for implementing health interventions to lower administrative levels and emphasizing the role of the central Ministries in the setting of standards, norms and procedures.

3.2 | Co-ordination of reproductive health programs

In 1997 the government established a special commission (*Comisión nacional de Coordinación de la Política de Planificación Familiar y Salud Reproductiva*, COORDIPLAN) which has the responsibility of coordinating, monitoring, evaluating and promoting the plans and programs in the field of population, family planning and reproductive health, in particular the National Population Plan 1998-2002. COORDIPLAN consists of the vice-ministers of the Ministry of Health, PROMUDEH, Ministry of Education, Ministry of the Presidency (PRES), Ministry of Regional Development and the presidents of the Peruvian Social Security Institute (IPSS), the National Statistical Institute (INEI) and the Environmental Council (CONAM) (cf. Annex 2).

In addition, August 1997, the *Mesa Tripartita de Seguimiento al Programa de Acción del Cairo* was created. This ad hoc consultative body consisting of 24 representatives of the government, national NGOs, universities and international donor agencies (multi- and bilateral) is a forum for the exchange of information. Its purpose is to co-ordinate and to evaluate the implementation of the ICPD PoA in Peru, to identify constraints and set priorities. The UNFPA played an important role in the establishment and functioning of this consultative body.

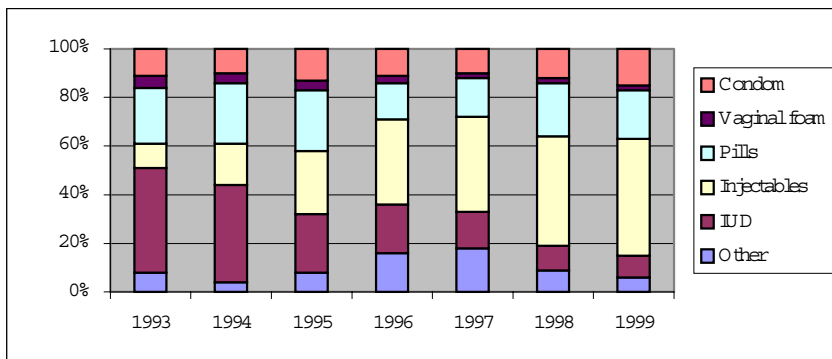
3.3 | Family planning

Family planning has remained a controversial issue in Peru and the government has had to proceed step by step in the incorporation of family planning in its development policies. Family planning services of the Ministry of Health (MINSA) have existed since 1983.

In 1991 the National Family Planning Program 1991-1995 was launched, which aimed at increasing the coverage of family planning services to all regions in Peru, prioritizing under-served areas and increasing the contraceptive prevalence rate (CPR). The program is mainly concerned with service delivery through 6000 service delivery points (4,000 health posts/clinics, 1,500 health centers, 500 hospitals), plus provision of contraceptives and counseling. The program has a national coverage and is still basically vertical. The Fujimori government has increased funding for family planning since 1995. Some activities are coordinated with other departments within MINSA such as Maternal/Perinatal Health, Adolescent Health and PROCETSS.

The National Family Planning program, resorting under the Ministry of Health, currently has a special status in that it receives its funding directly from the national budget (*Tesoro Publico*) since 1996, in contrast to the other fourteen programs within MINSA connected to the Basic Health for All Program (*Programa de Salud Básica para Todos*). The family planning program is thus independent from the other programs and funding is not dependent on consultations with the other MINSA programs for its budget.

Figure 3.1. Peru, contraceptives distributed through MINSA, 1993-1999



Source: MINSA.

Since 1996 contraceptives are delivered for free, including counseling, surgical contraception, and sometimes including free transportation to the health clinic in isolated areas. This has greatly increased demand for public services and made the position of NGOs and private providers more difficult as they lose clients and income. The demand for injectables has gone up considerably, but the demand for condoms and pills is relatively stable (Figure 3).

Service delivery is integrated at the lowest level, but not fully at the secondary (gynecology/obstetrics) and tertiary levels (family planning). The choice of contraceptives the program offers is limited to one of two brands of condoms, IUDs, injectables (Depo-Provera), oral pills and spermicides, but they are free. MINSA procures the contraceptives through UNFPA that buys them at low cost in the USA. From 1998 on priority is given to the improvement of counseling and quality services.

3.4 | Women's promotion and development

In general, government policy is aimed at reducing population concentrations in cities, promoting women's rights and giving priority to programs and projects that further foster gender equality and equal opportunities between men and women. The governments' priority for 1995-2000 is the increased access to family planning services and information, sexual education and the improvement of the social and health status condition of women.

A major step forward in working towards gender equity, and equal opportunities and rights for men and women, was the creation of the *Ministerio de Promoción de la Mujer y del Desarrollo Humano* (PROMUDEH) in October 1996, which took over the functions of other agencies (e.g. the National Population Council) concerning population, especially women's promotion. Specific objectives of PROMUDEH are:

- Promotion of gender equity in access to education, health and employment;
- Fostering the participation of women and the family in society;
- Developing and implementation programs aimed at prevention and care for infants and adolescents in risk.

PROMUDEH has developed a Plan of Action for Women to speed up this process and has devised the new *Plan Nacional de Población 1998-2002*, on the basis of the existing population policy. PROMUDEH consists of three directorates: one for women's promotion (*Gerencia de Promoción de la Mujer, GPM*), one for human development (*Gerencia de la Desarrollo Humano, GDH*) and one aimed at activities for children and adolescents (*Gerencia de promoción de la Niñez y Adolescencia, GNPA*).

The GNPA started its activities in October 1996 and endorses the principles of the ICPD and Beijing Conference of 1995. The mission of GPNA is to promote and protect the rights of children and adolescents, including reproductive rights. They work in the fields of prevention of unwanted pregnancies, violence, HIV/AIDS and responsible parenthood through advocacy, sensitization of policy makers and capacity building. The GPM develops programs in the field of evasion of domestic violence, furthering gender equity and capacity building, with the aim of improving the lives of women in poverty. The GDH has a coordinating function in relation to the implementation of the population plans. The GDH serves as the general secretariat of the COORDIPLAN, which is the highest coordinating body of the government in the population field. The COORDIPLAN devises and monitors the execution of the Population Plan.

PROMUDEH works through the *Oficina nacional de Cooperación Popular* (CooPop) for local level promotion of (reproductive) health services. This is done by collaborating with local level actors (*Comedores Populares, Promotoras de Salud*) and community based organizations (CBOs) such as *Clubes de Madres* and the *Comités de Vaso de Leche* (PROMUDEH 1998).

PROMUDEH executes the Wawa Wasi Program, aimed at IEC on nutrition, infant care and reproductive health for women with children under three years of age. Currently, the Wawa Wasi program covers 15 districts in Lima conglomerate and 25 departments in Peru, catering to 27 million children and their mothers.

In the context of the national alphabetization campaign, PROMUDEH provides IEC on reproductive health issues, gender equity, domestic violence and nutrition.

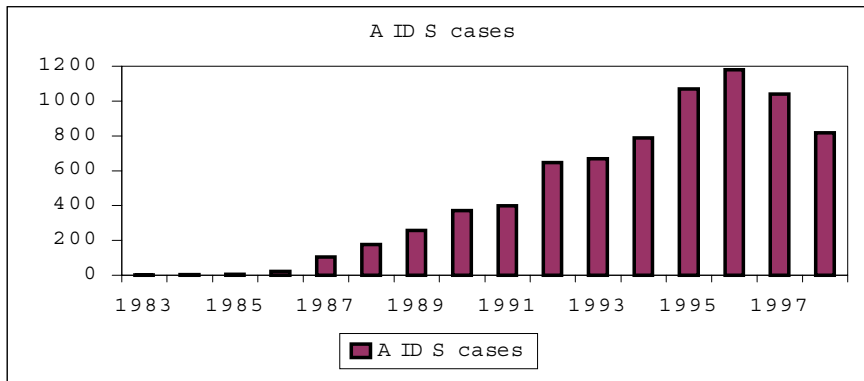
3.5 | HIV / AIDS and other STD activities

The spread of HIV/AIDS has become an issue of concern for the Peruvian government. Although the number of sufferers from HIV/AIDS is still relatively limited (17,191 HIV infected and 8,742 AIDS sufferers in June 1999) the government is aware of under-registration and of the incremental growth of the number of cases (Figure 3.2). Sexual intercourse is the main mode of transmission as of yet. Groups most at risk are those between 20-39 years old (almost three quarters of cases), homosexuals, sex workers and intravenous drug users. However, heterosexual transmission is on the increase. Registered cases of vertical transmission are limited as of yet.

The *Programa de Control de Enfermedades de Transmisión Sexual y SIDA* (PROCTSS) started end 1995 with its activities. The main objectives and strategies of the program are (MINSA, 1996):

- The reduction of the transmission of STDs and HIV, through strengthening of diagnostics and bloodscreening activities
- Reduce vertical transmission by promoting FP among HIV positive women and prenatal screening of STDs
- Reduce the socio-economic impact of HIV/AIDS on individuals, through promotion of human rights, countering stigmatization and improving the quality of health services
- Improve effectiveness of interventions through institutional strengthening, intersectoral co-ordination, at all levels of administration.
- Promotion of community participation and co-ordination of donor funding

Figure 3.2. Peru, number of registered AIDS cases by year, 1983-1998.



Note: excludes 836 cases with unknown year of registration.

Source: PROCETSS, 1999.

PROCETSS pays particular attention to high-risk groups such as gay men, transvestites, sex workers, truck drivers and adolescents. Promotion and IEC materials produced by PROCETSS are tailor-made for each group. PROCETSS does provide drug treatment but only provides Highly Active Anti-Retroviral treatment (HAART) for pregnant women; not for other groups as this is too costly for their tight budget. PROCETSS monitors STDs and processes statistics at central level. Relevant international publications in journals are translated and distributed by PROCETSS.

So-called STD reference centers have been set up in the whole of Peru. The CERETS are centers where tests can be done next to counseling and distribution of free condoms. Some centers do have less laboratory facilities and cannot do tests. There is one mobile unit in the harbor of Callao (Lima).

Basically, PROCETSS works with peer group educators (*promotores*) in some regions and with Health Brigades in others (integrated with other services of MINSA). Initially, PROCETSS contracted out the training/capacity building for their workers to NGOs such as Via Libre, but due to budget considerations this was not continued. PROCETSS now trains own health promoters. In 1999, there were 1,000 contact-distribution points (bars, hairdressers, cinemas, et cetera) for gay men in 10 cities. In Lima there are five clinics catering to gay men that offer free treatment for STDs. In the adolescent program, the peer educators do not work in schools but work with youth at other locations.

The Army and Police have their own STD/AIDS prevention programs through the COPRECOS (*Comité de Prevención y Control de SIDA*) since 1992.

3.6 | Other programs and interventions

Other notable measures taken by the Peruvian government related to the Cairo and Beijing plans of action are the formulation of the *Plan Nacional de Acción Mujer y Desarrollo* which aims at the improvement of gender equity, personal and social development of women and human and political rights. To improve the political representation of women, the *Ley Orgánica Electoral* prescribes that at least 25 per cent of the political representatives are women.

In the field of the eradication of the violence against women and domestic violence, a *Comisaria de Mujeres* has been created in 1988, and in December 1993 the *Ley de Violencia Familiar* was promulgated. This has promoted recognition of violence as a social problem and turned the attention to women's rights. Special commissions have been set up to safeguard the promotion and defense of women, e.g. the *Defensoría especializada en derechos de la mujer al interior* (1996) and the *Comisión de la Mujer, Desarrollo Humano y Deportes del Congreso de la República*. In addition, the government has actualized the ratified *Convención para la Eliminación de Todas las Formas de Discriminación contra la Mujer* (CEDAW) and in 1996 adopted the *Convención para Prevenir, Sancionar y Erradicar todas las Formas de Violencia contra la Mujer*. Finally, to promote the role of women in society, priority has been given to women's education: a national program aims at the reduction of female illiteracy from 15 per cent in 1995 to 6 per cent in 2000.

MINSA has initiated the *Programa Nacional para la Atención Integral del Escolar y Adolescente 1997-2001*, as a follow up of the *Programa de Salud del Escolar y Adolescente* (1990). Its general aims are capacity building, enlightenment and promotion of RH services for adolescents.

The Ministry of Education (MED) has integrated IEC on reproductive health, FP and population for adolescents in the schooling system. In order to implement IEC on population for adolescents, MED has appointed special IEC officers (*Guías de Educación Familiar y Sexual*) within the school system to instruct schoolteachers. NGOs across Peru are sub-contracted for this purpose. This capacity building effort currently involves around 2,500 schoolteachers at

primary and 24,000 at secondary level. In addition, in 1997 a Free School Insurance Program has been introduced and in 1999 a Maternal-Child insurance will be introduced.

The Ministry of Labor (MINTRAB) has implemented the *Programa Femenino de Consolidación del Empleo* (PROFECE) aimed at employment creation for women. The *Programa Nacional de Apoyo Alimentario* (PRONAA), aimed at food security and income generation for women, through capacity building, management and technical training and credit facilities, is being managed by PROMUDEH since 1996. In addition, MINTRAB has developed a programme for the vocational training of youth (PROJOVEN), including a reproductive health component. In the first three years PROJOVEN aims at a coverage of 30,000 adolescents of both sexes in poor (peri)urban areas.

Sound population policies are based on sufficient and adequate information and analysis on population. The National Institute of Statistics and Informatics (INEI) has the responsibility to provide basic information and analysis of population issues. Recent main projects have been the national Census 1993 and the DHS surveys (*Encuesta Nacional Demografía y de Salud Familiar* 1996, ENDES). In 2000 the next population census is to be held.

3.7 | Institutional framework and budgeting system

One of the weaknesses of the current health system in Peru is its complexity and the under-utilization of health services due to cultural constraints and duplication of efforts (e.g. public clinics, ESSALUD clinics, private institutions offering same services in the same locations). Within the health sector, the monitoring system is still underdeveloped, which obviously impairs budgeting and planning.

The health budget is drawn up annually according to national priorities and past trends in allocations. MINSAs get their funds directly from the central budget. MINSAs headquarters manage the budget for the health sector in Lima and Callao regions and for the central administration. The Office of Planning and the Budget (*Oficina General de Planificación y Presupuesto, OPSP*) of the Ministry of Health is responsible for the internal distribution of MINSAs funds over the departments and programs at central level. The different programs are still basically vertical. The different departments make their own plans and negotiate

the funding with the OPSP. The budget provisions are not based on real expenditures but on past trends in allocations. Although family planning still receives the larger share of funds, MINSA has also prioritized maternal mortality, gynaecological cancers, domestic violence and HIV/STDs. At lower levels the services are more integrated than the MINSA central level. However, the current plans to reform the health sector also comprises the integration of the vertical programs managed by MINSA under one MCH directorate.

The Ministry of the Presidency (*Ministerio de la Presidencia*, PRES) draws up the regional health budgets. As the health situation varies by region and department, priorities and financial needs are determined in consultation with the general health directorate and the regional health departments. The funds for the regions (including those for infrastructure and salaries) are channeled from the PRES to the regional governments (*Consejos Transitorios de Administración Regional*, CTAR), some of which are managed by FONCODES (Peruvian Social Investment Fund) or INFES (*Instituto Nacional de Infraestructura Educativa y de Salud*). As to external funding, it is possible that the regions get funding directly from abroad; for instance Switzerland and the Netherlands fund regional health projects.

At the local level, although the CLAS units formulate their needs and proposals for health interventions, the exact allocation of funds for equipment, infrastructure, services and training is determined at central level. In the case of the allocation of *non-refundable resources*, MINSA health specialists design the health intervention under the coordination of OPSP and the Office for External Cooperation (*Oficina de Cooperación Externa*, OFICE). In the case of *refundable resources* coordination is the responsibility of the Ministry of Finance. The monitoring of broad-based interventions (e.g. World Bank projects) is still done at central level, in contrast to projects with a smaller focus whereby the responsibility is devolved to the regions. As to foreign funding, OFICE is establishing an interdepartmental board for the development of policy and procedures for handling of donor funds.

The government resources are channeled through the main MINSA office and the Regional Health Offices. Next to government funding, MINSA receives funds through private household spending on services via public sector clinics and from external donors. Costs (including personnel) for the CLAS are paid through the MINSA budget.

A pilot System of Programming and Budget (SPP) is being implemented in 14 sub-regions of Peru. Via this system resources are allocated in concordance with the annual planning for health. The Health sector reform is laid down in the Sector Policy Guidelines 1995-2000 of MINSA.

Despite these changes the World Bank (1998:45-47) concluded that the MINSA budget is still fragmented and that there is some duplication of activities in their programs. MCH is under the responsibility of the *Dirección General de Salud de las Personas* (DGSP) and split up into eight national programs, including maternal-perinatal health, family planning, adolescent health and the STD/HIV/AIDS program. The programs are vertically integrated with separate planning offices, information systems, finance and policy units. Within MINSA, the budgeting system is fragmented. Fixed costs (labor costs, pensions) are paid by the treasury, while specific costs for the interventions are paid by the project budget lines and from tariffs.

4. Financial Flows

In the following sections, the focus will be on the financial aspects of interventions and programs in the Peruvian population and health sector. Paragraph 4.1. deals with the role the international donor community has played in past and present health sector and population programs, followed by an overview of the major bilateral and multilateral donors, and NGOs in this field. Next, the role of the Peruvian government and Peruvian NGOs is discussed, with an overview of the major projects and programs. The final section focuses on the private sector.

4.1 | The Role of the International Donor Community

4.1.1. *Development of foreign donor funding in Peru*

The total amount of donor expenditures for population activities in Peru has quadrupled in the last decade, from US\$ 5,2 million in 1987 to US\$ 21,3 in 1996 (GPAR report, 1997). This figure increased further to US\$ 29,6 million in 1997 and US\$ 28 million in 1998 (preliminary figure). This includes funding from bilateral donors, UNFPA, UNAIDS, several foundations (e.g. Ford Foundation, Nippon Foundation) and intermediate donors (e.g. Pathfinder, AVSC, HIVOS).⁴

In 1996 the bulk of donor expenditures went into family planning (53 per cent), with a lesser share for reproductive health (31 per cent) and basic research (15 per cent). A mere one per cent of donor funds were spent on HIV/AIDS projects and programs. In the following years there was a trend in more expenditures for reproductive health and HIV/AIDS activities (Table 4.2).

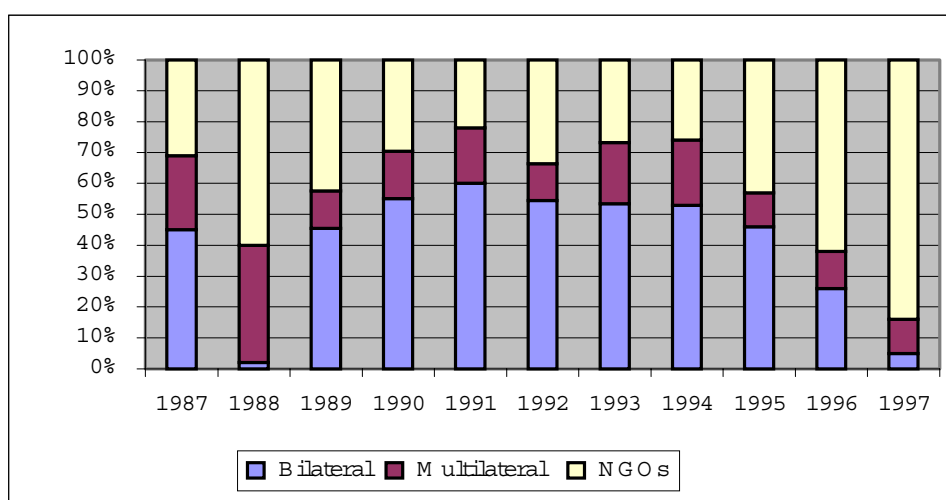
⁴ These figures are corrected for double-counts, such as funding from bilateral donors channeled through multilateral organizations or international NGO's.

Table 4.2. Peru, Donor expenditures by year and ICPD category

	Total US\$	% FP	% RH	% AIDS	% BS
1996	21.272.826	53,2	31,1	1,1	14,7
1997	29.563.625	49,9	36,0	3,7	10,4
1998	27.915.025	48,6	35,8	9,0	6,7

Source: RF database

Figure 4.1: Donor expenditures for population activities by channel, 1987-1997



Source: GPAR reports; RF database.

As is shown by Figure 4.1, the bulk of donor expenditures have been flowing through the bilateral channel for most years, although since 1995 the NGO channel has become more significant.

4.1.2. International Donors in Population and Development

A. Donor countries

USAID

USAID started new health/population activities in Peru in 1993. From the start family planning has remained an important component, but attention has shifted to maternal-perinatal health, MCH, cervical cancers, HIV/AIDS and STDs. The priorities are improvement of the quality of services and institutional strengthening, within the process of decentralization. USAID carries out their program on central level with the vertical programs (FP, maternal-perinatal) and on the regional/local levels. Current USAID activities cover the improvement of family planning and reproductive health services, adolescent health, IEC and sexual education, local capacity building and training, contraceptive choice, institutional strengthening, cervical cancers: training, HIV/AIDS and healthcare financing.

The strategic objectives of USAID's program in Peru are to foster broader citizen participation with more responsive public institutions, poverty alleviation, improved health of high-risk populations, including family planning and improved environmental conditions. USAID is the largest donor in family planning and provides complimentary contraceptives, next to support for population research, management and service delivery. USAID provides support to Peruvian public sector institutions and local NGOs in order to strengthen and improve basic health care services including family planning and MCH. Table 4.3 shows USAID project portfolio of the past years in a nutshell.

Table 4.3. USAID programs and funding in Peru

Acronym	Authorization date	Termination date	Grant funds	Counterpart funds	Executing agencies
SHIP	28-9-1991	31-12-1999	20.746.000	1.000.000	CARE; Univ. Research Corporation
PASARE	30-9-1993	Continuing	6.000.000	0	MINSA; USAID-CoopAgencies
Project 2000	30-9-1993	30-9-2000	30.000.000	30.000.000	MINSA; PATHFINDER; CARE; Dev. Associates
REPROSALUD	21-8-1995	27-9-2000	25.000.000	0	Manuela Ramos; Alternativa
AIDS Help	26-9-1996	30-9-1999	1.000.000	387.285	MINSA/PROCETSS
FP Public sector	23-9-1996	30-9-2001	2.400.000	363.870	MINSA; PRISMA
ALCANCE	10-1-1997	25-9-2003	8.099.964	0	PRISMA; PATHFINDER
PD&S	sep-96	sep-98	466.915	67.600	
Good Start	28-9-1998	27-9-2003	3.200.000	1.100.000	UNICEF
VIGIA	29-9-1997	28-9-2004	18.000.000	6.000.000	MINSA; CDC/NARID

Source: USAID/Peru

SHIP (Strengthening Health Institutions Project) is aimed at increasing the coverage of high quality and financially sustainable PHC services among low-income populations in Peru, including private sector capability. Innovative models of service delivery are being tested in three regions of Peru (Puno, Arequipa, Chiclayo).

The Reproductive Health Assistance Plan (PASARE) aims at quality improvement and coverage of reproductive health services in the public sector. Technical and financial assistance is provided to the MINSA covering the components of service delivery, management, IEC, evaluation and research. Under the program, national RH guidelines and education materials have been developed, health personnel trained (e.g. reproductive health, logistics, information systems, management, evaluation, and advocacy) and policy analysis has been executed. The program makes use of executing agencies such as CARE, the Futures Group, INTRAH, JHPIEGO, MACRO, PATHFINDER, and the Population Council.

Project 2000 is aimed at improving the quality of MCH interventions and increasing its coverage, utilization and sustainability. The project supports three

components namely MCH services, efficient management and health care financing. Health interventions address maternal and perinatal health and family planning, breast-feeding, child nutrition and respiratory diseases. The project is funded from USAID (total US\$ 30 million) with counterpart funding from the Ministry of Health (US\$ 30 million). The twelve health sub-regions covered by the program actively participate in design and implementation. Executing agencies such as CARE, Pathfinder and Development Associates, with USAID funding provides technical assistance for the project.

The Reproductive Health in the Community (REPROSALUD) project aims at increasing the coverage and use of family planning and reproductive health interventions in target areas. Included in the multi-sectoral program are activities aimed at self-diagnosis of reproductive health needs by CBOs (e.g. *Clubes de Madres*), income-generating and credit activities linked to reproductive health, advocacy and IEC and technical and financial support for institutional strengthening. In addition, community based health promoters are trained in reproductive health issues.

The main purpose of the Healthier Lives through Prevention (AIDS Helps) project is to strengthen the activities carried out by PROCETSS at central and regional levels. Capacity building is also aimed at the private and NGO sectors in this program.

The Family Planning Public Sector Support program aims at developing a sustainable contraceptive management system, next to improving the quality of public sector family planning services. In this effort, the nationwide contraceptive distribution system implemented by the Peruvian NGO PRISMA is supported. USAID supplied contraceptives for MINSA's Family Planning program are distributed through PRISMA, and procured with USAID/Peru funding through UNFPA. Currently, MINSA has procured 5,5 million Nuevo Soles (US\$1,5 million) worth of contraceptives (Depo-Provera). The procurement and logistics of MINSA/Prisma have received technical support by John Snow Inc. The year 1998 was the first year that the national funding of the national FP program superceded the international support: the program has become self-supporting.

The Family Planning within Reach of High-Risk Populations (ALCANCE) is designed to reduce reproductive health problems such as maternal and infant mortality, unsafe abortions and unwanted pregnancies, through the increase in

coverage of family planning and reproductive health services among high-risk populations. Under the program, Peruvian NGOs receive funding, training and technical assistance. NGOs working in peri-urban and rural areas in particular are targeted.

Under the VIGIA program (Addressing threats of Emerging and Re-emerging Infectious Diseases), the public health system is strengthened and capacitated in order to adequately tackle the problem of infectious diseases in Peru, including HIV/AIDS. The program supports the country's surveillance system, research and laboratory capacity and prevention and control activities.

USAID funds its Peruvian programs through four different mechanisms:

1. Field support: aid earmarked for health services in Peru and channeled through US based NGOs (JPIEGO, MSH, PATH, INTRAH)
2. Contracts for projects: e.g. the PASARE program via PATHFINDER, CARE, Peru; mainly technical support.
3. Co-operative agreements: grants to local NGOs, e.g. the ReproSalud, ALCANCE and MaxSalud under the Strengthening Health Institutions Project (SHIP), which work with Movimiento Manuela Ramos, Alternativa, and CARE-Peru.
4. Bilateral grants: e.g. Project 2000.

In the period 1996-1998, USAID expended a total of US \$ 34 million on its programs in Peru. USAID is currently phasing out its support to Peruvian programs, in particular to the family planning program. In general splitting up activities into ICPD categories is complicated due to integrated programs. USAID-Peru works with three broad categories: 1) health, 2) population and 3) nutrition. Some programs contain elements of two or three of these categories. However, the bulk of USAID funding went into family planning.

DFID (formerly the Overseas Development Administration-ODA)

The British Department for International Development (DFID) has been involved in health issues in Peru since late 1995. The general aim of DFID's technical co-operation program is to capacitate the Peruvian government to devise better health policies and programs. The main focus has been on: 1) the health sector reform process, with attention to policy development, strengthening local health networks and inter-departmental co-ordination and 2) the improvement of availability and quality of reproductive health services with

particular attention to maternal mortality and post abortion care. DFID policy aims at building partnerships with the central and local governments, other donors, civil society and the private sector. DFID's total planned budget for health and population increased from US\$ 1.7 million (£ 1.04 million) in 1997/8 to US\$ 3.5 million (£ 2.1 million) in 2000/01 (DFID 1998).

DFID's activities include:

- the provision of contraceptives (Norplant, Depo-Provera) for MINSA since 1995; total budget is £ 1.5 million (US\$ 2,4 million).
- a multi-sector population project, co-funded with USAID, aimed at capacity building in HIV/AIDS prevention and family planning. The project started in 1996 and will be extended until 2001; the total budget is £ 1.8 million (US\$ 2,8 million).
- the Andean reproductive health initiative, started in 1999 in Cooperation with the European Community, is aimed at identifying reproductive health needs of selected Andean communities. The initial budget is £ 2 million (US\$ 3,3 million).
- health policy development in Cooperation with MINSA, aimed at five specific areas namely family planning, maternal-perinatal care, cervical cancers, HIV/AIDS and adolescent health. This activity is budgeted at £ 5 million (US\$ 8,2 million) for the period 2000-2005.
- the papsmear reading research project is ongoing; MINSA has received £ 250,000 (US\$ 400,000) core funding for this activity.

The DFID supported projects are aimed at the regional local levels, but co-ordinated at the central level of MINSA.

The Netherlands

The Dutch support for Peru has been in the field of sanitation and drinking water, primary health care and reproductive health. At present, due to a change in Dutch policy, by which development assistance is to be concentrated in fewer countries, the Dutch supported projects are being phased out by the end of 2000. However, in order to guarantee sustainability, the Dutch Embassy in Lima is making efforts to transfer some projects to other interested donors such as the UNFPA or to the Peruvian government (MINSA), but at the time of the mission there were no guarantees. In general, Dutch supported projects executed with NGOs (e.g. INPPARES, APROPO) are funded directly. The NGOs should be

commissioned to train MINSA staff, with MINSA approval is needed (e.g. INPPARES projects).

The currently active projects of the Netherlands in Peru are:

Atención Primaria de Salud y Saneamiento Básico en Cajamarca (APRISABAC). The project is aimed at the improvement of quality and coverage of PHC and sanitation in Cajamarca. This project runs from 1993 to end 2000. Total funding is US\$ 9,200,000. The project has recently been positively evaluated. The Netherlands tries to guarantee its continuation by integrating it into the MINSA program. This is still under negotiation and due to the upcoming elections the outcome is unclear.

Atención de Salud a Poblaciones dispersas en Ayacucho. This is a regional pilot project in the department of Ayacucho aimed at improving integrated health services in isolated areas, with a special focus on the dispersed population of Peru (15 per cent of population). This group of people became displaced during the political upheavals and terrorist campaigns of the 1980's and early 1990's, and forms an under-served group in terms of health programs. Total funding is US\$ 200,000 for the period 1998-1999. The project is to be continued. For the second phase US\$ 2,5 million will be donated to MINSA for three years and will be executed in the provinces Cangallo, Vilcashuaman and Victor Fajardo. USAID is doing a similar pilot project in San Martin department.

The reproductive health project *Promoción y Capacitación en Salud Reproductiva y Perspectiva de Genero* is done in collaboration with the Peruvian NGO INPPARES. Total funding was US\$ 650,000 for the period October 1997 to October 2000. The project is implemented in the departments of Ayacucho, Cusco and Loreto. The first is already phased out. NL tries to market this program to MINSA. The project is aimed at IEC for illiterates on reproductive health and family planning. It is a client based approach and promotes IEC material in the indigenous language Quechua to be used by MINSA staff working in the areas.

Fascículos de salud sexual y reproductiva para medios impresos-APROPO. This project is aimed at IEC on reproductive health, gender equity and family planning through printed media (e.g. the newspaper Expreso). It is done in collaboration with the local NGO APROPO. It is a national program covering a target population of 150,000 adolescents. Total funding is US\$ 69,500 for

November 1997 to December 1999. The project has been under pressure from conservative forces in Peru, which disapprove of the publication of family planning promotion materials.

Centro Comunitario de Salud Mental de Villa el Salvador–CECOSAM. This projects works with adolescents, infants, parents and teachers on the themes of domestic violence. It is aimed at reducing violence and providing emergency therapy to abused children. They work with promoters of health for IEC and use family therapy for reduction of domestic violence.

In addition to these projects, the Netherlands supported two small health projects in 1998 (with funding for each of US\$ 20,000): the first is a project on institutional strengthening of family planning in Ayacucho (finalized) and a hospital study on TB.

The European Union

The European Union set up a delegation in Lima in 1991. Its program supports programs in the field of health, rural development, basic infrastructure and food security. In 1996, the EU supported activities on STD management and HIV/AIDS prevention for ECU 150,000 (US\$ 190,000). There are no specific reproductive health programs at present. However, the EU is planning to set up a reproductive health initiative in Andean communities, aimed at identifying their reproductive health needs. It will start at the end of 1999 and will be executed in cooperation with DFID. The proposed budget is pounds sterling £ 2 million (US\$ 3.2 million).

B. International NGOs and Foundations

PATHFINDER International

Pathfinder International is present in five Latin American countries. Since 1970 it has implemented projects and programs in Peru, funded by USAID, DFID, the Worldbank and private U.S. foundations. Pathfinder is one of the major NGOs in Peru. It focuses on establishing, expanding and improving the quality of family planning, reproductive health and MCH service delivery. Pathfinder works in close collaboration with MINSA, MED, ESSALUD and local NGOs. Pathfinder participates in the Tripartite Commission, established to assess the achievements and obstacles in the implementation of the ICPD. Pathfinder has currently a staff of 30 in Peru and an annual budget of US\$ 1,2 million.

Pathfinder's major programs and projects in Peru are:

Project 2000 (September 1993 – September 2000) is a major project of Pathfinder in Peru. The aim is to increase the use of child and maternal health care interventions in 11 departments throughout Peru. Within Project 2000 Pathfinder cooperates with a variety of organizations, including CARE Peru and Development Associates. Pathfinders budget for this project is US\$ 15 million for five years. A second phase is currently being negotiated for three years.

In 1992 Pathfinder has implemented the *Comprehensive Postpartum Project (CPP)* to increase awareness among pregnant women and young mothers of the importance of postpartum health and family planning. In Peru, together with the FOCUS on Young Adults Program, Pathfinder works in collaboration with MINSA on training of service providers in MINSA clinics and with MED in evaluating the National Sex Education Curriculum of elementary schools and developing a sex education curriculum at secondary level schools. In addition, Pathfinder and FOCUS implemented a training curriculum and training of trainers on IEC for service providers targeting youth and adolescents. The project receives DFID funding and is executed in 13 hospitals, but will be expanded to 30 hospitals. Furthermore, the project has been evaluated favorably twice and serves as a model for implementation in other countries.

Pathfinder works together with USAID and the private organization A.B. PRISMA in the ALCANCE project (July 1997-July 2002). The aim of ALCANCE is to increase the use of FP and other selected reproductive health services among high-risk and under-served populations in Peru. Funding US\$ 3,8 million for 1999-2002.

Furthermore, Pathfinder works in cooperation with ESSALUD on an adolescent RH project, aimed at training service providers in user-friendly counseling. Funding is received from Pathfinder-HQ, channeled through MINSA. Pathfinder has assisted MINSA in the development of a protocol for emergency abortion and has supported the NGOs Flora Tristan and Movimiento Manuela Ramos in the field of sexual education and research on abortion practices.

Currently, Pathfinder is negotiating with the World Population Foundation (NL), DFID and the EU about a project on emergency contraception and gender-based violence in police stations. Pathfinder will be responsible for the RH/STD

component, whereas Flora Tristan will provide the legal component). Funding needed is US\$ 400,000.

CARE-Peru

CARE's Reproductive Health interventions focuses its attention on providing training and technical assistance to the Ministry of Health in supervising and developing networks of community promoters who provide reproductive health services and in improving maternal and child care. The community networks consist of peer group educators and community-based organizations. Promoters are trained to offer community members family planning guidance as well as to provide contraceptive methods. They aim at community involvement and ownership of projects and help communities to auto-diagnose their own health needs. The health promoters live and work in poor communities for several years; they do not get salaries but the incentive is free reproductive health and family planning services and contraceptives. The leaders of the community make their own reproductive health plans. Although CARE targets poor people in remote areas, CARE also works in poor areas around Lima.

CARE-Peru participates in several major Reproductive Health projects:

Multi-Sectoral Population Project (MSPP):

The aim of the Multi-Sectoral Population Project is improving the quality and availability of FP information and services for 300,000 families living in high-need areas. CARE provides material and technical assistance to the National Reproductive Health Services Program. US\$ 2,3 million has been spent on implementation and MINSA has contributed US\$ 2 million for equipment, materials and transport costs in the project. The involvement and support of MINSA is increasing year by year and in July 2000 CARE will carry over the project to MINSA. Result of the project in 1999: 429 health centers, 374 health committees, 2,270 health promoters and a coverage of 500,000 families all over Peru.

Project 2000: (1993-2000) Within Project 2000 (see section on USAID) CARE is responsible for strengthening maternal and child health care services and information, education and communication activities.

ENLACE-Child Survival

The aim of the project is, in coordination with the Ministry of Health and local organizations, to improve health and survival rates of children under five and women of reproductive age. The project reaches over 12,000 families using 25 health centers in 380 communities in the La Libertad Department. CARE provides technical assistance and training to the Ministry of Health and community health promoters.

Strengthening Health Institutions Project (SHIP) The goal of SHIP is to increase private sector capability to provide a greater coverage of quality primary health care, including reproductive health. Simultaneously, the activity's purpose is to test the effects of particular innovations in service delivery on programmatic, financial and social sustainability. SHIP operates in Puno and Arequipa in the South and in Chiclayo in the North. In the SHIP North Project CARE works in partnership with MaxSalud (local NGO). CARE provides technical assistance. SHIP is financed by USAID for the 1991-1999 period (Total budget US\$ 20,746,000), with GOP counterpart funding of US\$ one million.

Nippon Foundation

The Japanese Nippon Foundation is a private nonprofit organization, established in 1962. They provide grants to governments, NGOs and international organizations executing projects in the field of disaster relief programs, health, hygiene, education and international understanding. In fiscal year 1998 the Nippon Foundations provided overseas development grants with a total of US\$ 58 million (3 per cent of total revenues). In 1997, the Nippon Foundation supported Peruvian family planning programs in rural areas with a total expenditure of US\$ 2 million.

Ford Foundation

The Ford Foundation spent US\$ 360,000 in 1996 and US\$ one million in 1997 on population programs in Peru. These concerned projects aimed at fostering community involvement in health programs and support to social science research and training.

Population Council

The Population Council has been active in reproductive health activities in Latin America through the so-called INOPAL III program (Investigación Operativa y asistencia técnica en planificación familiar y salud materno-infantil en América Latina y el Caribe), funded by USAID. This program is aimed at research in the field of family planning and reproductive health in Latin America and the Caribbean, including post abortion care, perinatal services, cost-effectiveness and efficiency of family planning programs. The Population Council has been in Peru since the mid-1980's. Their collaborative work in reproductive health with Peruvian organizations has focused on the fostering of family planning (IUD, injectables), postpartum contraception and the improvement of post abortion care including counseling and contraceptive services. In addition the Population Council has supported research on male participation in reproductive health. Population Council has worked together with the Asociación Benéfica PRISMA in Lima (abortion, FP services) and population research institutions.

HIVOS

HIVOS is a Dutch NGO supporting development projects worldwide. In 1997 and 1998 HIVOS supported Peruvian NGOs implementing projects in the field of HIV/AIDS prevention. For instance, in 1997/8 HIVOS provided funding for HIV/AIDS workshops organized by Via Libre.

The total HIVOS funding for projects in Peru was US\$ 127,000 in 1997 and US\$ 80,000 in 1998.

Macro International

Macro International Inc. is an American based organization that supports demographic research, program evaluations and policy studies in developing countries. Macro International supported Peru in the execution by the national statistical office (INEI) of the DHS surveys. Total funding amounted to US\$ 1.2 million dollars during 1996-1998.

JHPIEGO

JHPIEGO activities in Peru are aimed at the expansion and strengthening of public and private reproductive health services. JHPIEGO provides IEC and training services on family planning and reproductive health issues to their partners in Peru. JHPIEGO is one of the executing agencies of the USAID sponsored Reproductive Health Assistance Plan (PASARE). Within this framework, JHPIEGO provided technical assistance and developed family

planning/ reproductive health training modules used at Peruvian medical and midwifery schools. In addition, with USAID funding, JHPIEGO developed reproductive health service guidelines and training on cervical cancers in cooperation with the Ministry of Health.

C. Multilateral Organizations

UNFPA

UNFPA has been active in Peru since 1972, and has supported more than ninety population projects with a total funding of over US\$ 46 million. The major part of these funds have been spent on reproductive health, in particular to the activities of the Peruvian Ministry of Health (MINSA) in the field of quality improvement of services and to the Ministry of Education for the incorporation of population and reproductive health into the school curricula. In addition, UNFPA has supported the work of the National Population Commission, the establishment of PROMUDEH and the executing of the national population censuses (1981, 1993) and DHS surveys (1986, 1991, 1996) by the National Institute for Statistics and Informatics (INEI). UNFPA has also supported and strengthened Peruvian NGOs working in the field of reproductive health, such as Flora Tristan, Movimiento Manuela Ramos and the *Red Nacional de Promoción de la Mujer*.

Next to advocacy, UNFPA's Fifth Peru Cooperation Program (1997-2001), is aimed at further development and strengthening of activities in the fields of IEC on reproductive health and sexual rights, improved access and quality of reproductive health services and capacity building aimed at incorporating population issues in national development policies and programs. Moreover, the program supports the process of decentralization through strengthening the regional population councils by way of capacity building, training and IEC activities.

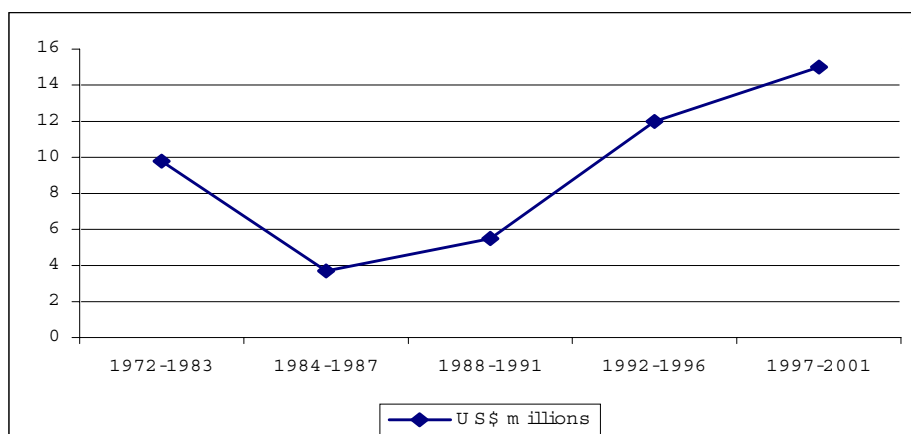
More specific activities in the field of reproductive health supported by UNFPA are:

- national Wawa-Wasi program; executed by PROMUDEH, and aimed at promoting sexual and reproductive health rights and capacitating men and women involved in the Wawa-Wasi program, which is aimed at providing integrated care for children under three.

- support of the national program of alphabetization, executed by PROMUDEH, and aimed at promoting and incorporating issues of sexual and RH rights and health practices in the alphabetization modules, particularly focussing on rural illiterate women.
- basic research on the needs and perceptions on reproductive health of indigenous men and women in 250 indigenous communities, executed by PROMUDEH
- training of adolescent peer educators on reproductive health in Lima, implemented by PROMUDEH
- RH and local health promoters, executed by PROMUDEH, in Lima and San Martin Departments
- IEC on unwanted pregnancies, abortion and HIV/AIDS for adolescents, executed by Ministry of Labor and Social Promotion.
- transmitting knowledge on reproductive health to parents, students and school youth at primary and secondary level through the capacitating of teachers, implemented by the *Centro de Estudios para el Desarrollo Regional (CEDER)*.
- incorporating issues of reproductive health in the school curricula national, in particular unwanted pregnancies and HIV/AIDS, through capacitating school teachers, executed by MED.
- monitoring and evaluation of the quality of national RH/FP services
- IEC and specialized services for men in Lima, Chimbote, Huancayo and Iquitos, executed by MINSA
- strengthening of management of MINSA RH/FP programs

To foster and monitor the implementation of the ICPD Plan of Action in Peru, UNFPA initiated the creation of the *Mesa Tripartita de Seguimiento a la Implementación del Programa de Acción de la CIPD* in August 1997. This forum, a unique initiative in Latin America, provides a solid basis for the exchange of information on the national reproductive health needs, prioritization and strategies to be followed in the successful implementation of the ICPD PoA.

Figure 4.2. UNFPA budget for Peru, 1972-2001



Source: UNFPA-Peru

Total UNFPA funding for the period 1972-1996 is US\$ 31 million. UNFPA funding decreased in the period up to 1985 after which it steadily increased. For the 5th program (1997-2001) total funding is US\$ 15 million, of which US\$ 5,5 million are multi/bi funds (Table 4.4). The actual UNFPA expenditures for the first two years of the 5th program US\$ 5,1 million. Of this amount 9 per cent was in support of family planning activities, 61 per cent for reproductive health, 3 per cent for HIV/AIDS and 28 per cent for basic research and policy analysis (RF database).

Table 4.4. UNFPA-Peru 5th Cooperation Program, 1997-2001

Area	Regular Funds	Multi-bi funds	Total
Reproductive Health	6,5	5,5	12,0
Population and Development	2,5	0,0	2,5
Advocacy	0,5	0,0	0,5
Total US\$	9,5	5,5	15,0

Source: UNFPA, 1998

ONUSIDA-UNAIDS

ONUSIDA is a focal point and has a coordinating function. It does not have its own budget from which it can finance large projects. Requests for project funding are forwarded to UNAIDS-HQ in Geneva for consideration. If approved, the funds go directly to the executing agency. However, ONUSIDA-Peru has assisted in some seminars and works with informal groups of people living with AIDS; these are IEC and advocacy activities. Next to this they only provide some technical inputs into projects of donors (multilateral organizations, such as UNDP, UNICEF). For operational costs UNAIDS –Peru spent about US\$ 360,000 in 1998 (RF database). In 1999, ONUSIDA supported UNICEF on a project with funds of US\$ 140,000 in 1999.

Pan American Health Organization – PAHO -OPS

In Peru, PAHO provided technical assistance to reproductive health projects executed by other organizations. PAHO mainly provides input in order to help other organizations to identify problems, devise policy and set priorities. The main focus is currently on reducing maternal mortality, with additional activities in the field of countering transmittable diseases (e.g. malaria, dengue fever) including HIV/AIDS.

The current main project of PAHO is *Promoción de la Salud* aimed at strengthening the national capacity for developing promotion strategies in integrated health services. The budget for the maternal mortality activity amounted to only US\$ 140,000 for two years.

Furthermore PAHO supports some research on transmittable diseases (HIV) in the populations displaced during the 1980s period in the Andes region. In Lima they support two IEC and prevention projects on HIV/AIDS, aimed at street youth. In the IEC projects PAHO works in cooperation with PROCETSS, ONUSIDA, UNICEF and the Peruvian NGO Via Libre. Extra budgetary funding for these projects was received from PAHO-HQ in Washington.

The World Bank

The World Bank started its Basic Health and Nutrition Program in 1995, which will be terminated in 2000. The program, covering project areas in 13 provinces plus two districts in Lima, supports the governments' poverty alleviation strategy. More specifically, its objective is to improve the health and nutritional status of poor women and children by increasing the use of MCH and nutritional services, improving access and quality of services and promoting better health

and nutritional practices, in particular in preventive care and education. The bank provides funding for technical assistance, basic equipment and medicines. The project comprises of five components, namely MCH, nutrition, TB treatment, IEC and management. The total budget for the project is US\$ 44 million, in the form of a US\$ 34 million bank loan and a counterpart contribution of US\$ 10 million of the Peruvian government.

The World Banks Peru Health Reform Project, implemented by MINSA, is aimed at improving the coverage, quality, efficiency and effectiveness of the Peruvian public health care system, with the goal to reduce maternal and infant mortality. The total cost of the ten-year program starting in the year 2000 is US\$ 300 million. The first phase of the program (2000-2003) will be financed by the World Bank (US\$ 50 million), with equal shares of US 50 million funded by an IDB loan and the Peruvian government.

This first phase is aimed at furthering integrated MCH services, modernizing clinics, reforming health care financing mechanisms and social security and strengthening MINSA's management and monitoring capabilities.

The Peruvian Social Investment and Compensation Fund (FONCODES) has been supported by the World Bank since 1994. The second phase (1996-1999), with a total loan amount of US\$ 150 million, funds community based projects targeted at poor and low-income groups aimed at the improvement of local economic-, educational- and basic health infrastructure.

Inter-American Development Bank (IADB)

The IADB provides support to the Peruvian health and social sectors, but has no program specifically geared to reproductive health. The IADB Program to Strengthen Health Services, with a total cost of US\$ 98 million is financed by an IDB loan of US\$ 68 million, supplemented by US\$ 20 million from Japan and counterpart funds of US\$ 10 million. The program consists of studies concerning health sector reform, the strengthening of the Ministry of Health and regional health directorates and support to health care establishments in the form of basic equipment, e.g. for obstetrical and neonatology centers.

From 1993, the IADB also supported FONCODES with an IDB loan of US\$ 100 million, supplemented with local funding of US\$ 43 million, for the

improvement of basic social services. One component of the program is support for the provision of basic health care infrastructure and equipment; the specific reproductive health component cannot be singled out.

4.2 | Role of the Government of Peru

In 1998 the public health sector consisted of 6,373 establishments including those of MINSA, the ESSALUD and health units of the Army and Police. MINSA caters to the poor population without public (ESSALUD) or private insurance, with services in marginal urban and rural areas.

ESSALUD is for the formal sector workers, mainly in the urban areas. The Army and Police have their own health services for personnel and their families. The private sector comprises of clinics, private physicians and some NGOs, mainly in the large urban centers, and had 933 establishments (13 per cent of total) in 1998. In general the institutional coverage has increased from 32 per cent in 1994 to 43.5 per cent in 1997 (PAHO 1998). About 23 per cent of population had health insurance of which ESSALUD (86.5 per cent), Army/Police (7 per cent) and private health insurance (6.5 per cent).

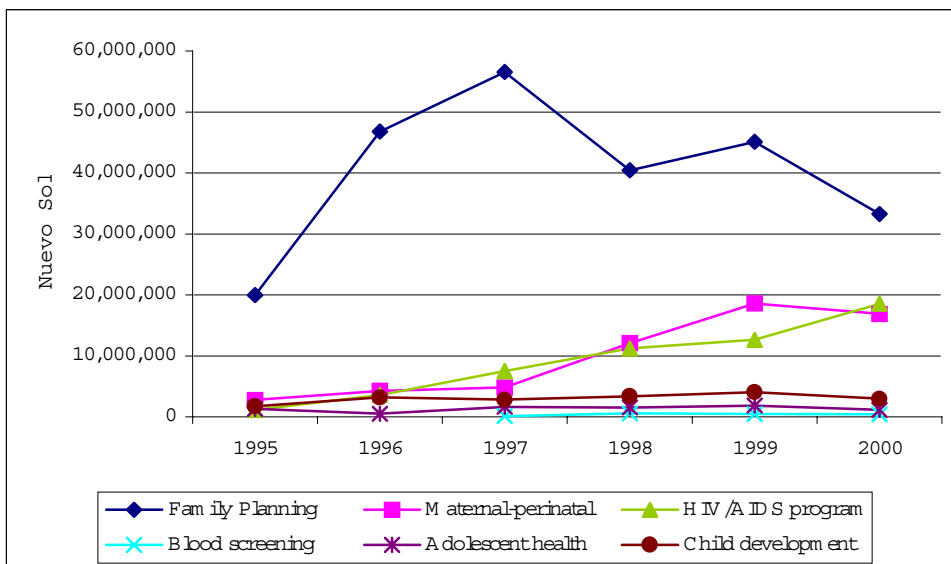
In the period 1992-1995 the total health expenditures represented approximately 3.5 per cent of Gross Domestic Product. In 1997 this was 4.1 per cent. In general, the governments' social expenditure increased since 1993, but the recent economic downturn is causing some budgetary problems at MINSA. However, the government programs are now sufficiently anchored to be sustainable; there remains a need for institutional strengthening and interdepartmental integration at central level.

The main central departments, dealing with reproductive health issues, are the National Program for Family Planning, Maternal and Perinatal Health Program, the national HIV/AIDS program (PROCETSS) and Adolescent Health, all in the Ministry of Health. Up to early 1990's Peru's health programs were vertical. Now, the reproductive health services fall under the Social Programs Department of the Ministry of Health, e.g. Family Planning, Maternal/Perinatal Health, School & Adolescent Health and control of cancers of the reproductive tract. The programs are still not fully integrated: each program has its own supervision, IEC program et cetera. Up to now, the Ministry of Health has no clear-cut policy of integration of programs so that the linkages are still weak.

Family planning stills receives most attention although there are efforts to integrate at PHC level. The program for the control of STDs and AIDS (PROCETSS) and maternal-perinatal health are separate departments.

As shown in Figure 4.3, the budget for family planning is far greater than for the other programs. However, after 1997, funding for family planning has leveled off while that for maternal-perinatal health and HIV/AIDS have shown a progressive trend after 1995. One reason for a decline in funding for family planning is the phasing out of USAID support to the Family Planning Program.

Figure 4.3. MINSA budget for national health programs, 1995-2000



Note: includes foreign funds.

Source: MINSA.

4.2.1. MINSA- National Family Planning program

From 1995, the National Family Planning Program (NFPP) had a separate budget under the treasury unlike the other health programs, which are directly under the MINSA budget (14 programs of the Basic Health Care for All Program; *Programa de Salud Básica para Todos*). In other words, the program is independent of the budget considerations and division of other MINSA programs. The funding for the program has increased significantly: in 1996 the

budget for the program was Nuevo Soles 24 million (US\$ 10 million), which increased to Nuevo Soles 36 million (US\$ 13.7 million) in 1997 and Nuevo Soles 40 million (US\$ 15.2 million) in 1998 (PROMUDEH 1999).

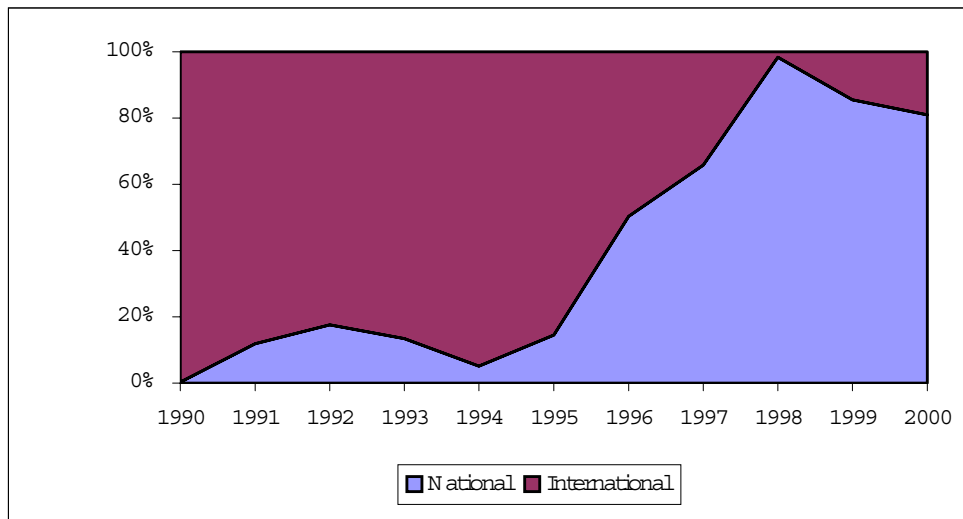
International funding for the National Family Planning program has come from the UNFPA, USAID, DFID, IPPF, JICA and PAHO (OPS). Contraceptives for the Family Planning Program are provided by USAID directly through PRISMA, a Peruvian NGO that takes care of the distribution within Peru since 1990. The IPPF has provided equipment and contraceptives through its affiliate INPPARES (see section below).

The share of foreign assistance for the National Family Planning Program shows a decreasing trend since 1994 (Figure 8).

4.2.2. *MINSAs- National Program of Maternal-Perinatal Health*

The National Program for Maternal-Perinatal Health (NPMPH) was created in 1992 under the *Dirección General de Salud de las Personas* of MINSAs. Up to 1996 however, the program was quite ineffective due to a lack of funds and protracted political decision-making. Political interest has now translated in the launching of the emergency program for the reduction of maternal mortality and an increase in funds. However, although the government has prioritized safe motherhood, the program is still understaffed. In addition, stocks of medicines are insufficient and the NPMPH has to prioritize those regions with highest maternal mortality rates. The NPMPH has created television spots and radio messages on safe motherhood, but lacks the funds for its dissemination. The regional directorates are responsible for its distribution to regional TV channels and radio. Despite the low investments in the program, the perinatal control has improved from 24 per cent of pregnant women at the start of the program to 78 per cent at present. However, maternal mortality is still very high.

Figure 4.4. Peru, National and international funding for the National FP program, 1990-2000



Currently, there are three active programs:

- Refuges (*casas de reposos*) for pregnant women in two regions started in 1998. These are funded by USAID and will be terminated in February 2000;
- Integral attention for abortion, with funding from Pathfinder and DFID.
- Safe Motherhood Program, financed by UNICEF which ended in November 1999.

NPMPH works in coordination with PROCETSS and the Family Planning program: PROCETSS supports the identification of women with AIDS and the department of FP supports staff training.

The approved annual budgets for 1998 and 1999 were 18 million Nuevo Soles (US\$ 6.2 million), of which only 12 million Nuevo Soles (US\$ 4.1 million) and 8 million Nuevo Soles (US\$ 2.7 million) were received respectively. For the year 2000, the approved budget is 16 million Nuevo Soles (US\$ 5.5 million).

4.2.3. *National Program for the Control of Sexually Transmitted Diseases and HIV/AIDS - PROCETSS*

PROCETSS gets its money from the MINSA budget, but gets additional funding for procurement of condoms directly from the public treasury. In 1999 the government has cut back funding for PROCETSS. Some duplication of activities is taking place as the National Family Planning Program and the Department for Maternal-Perinatal Health also develops HIV/AIDS prevention and control activities. Although target groups are different, the setting up of separate distribution points sometimes means duplication and an inefficient use of resources.

The fact that PROCETSS prioritizes prevention activities high risk groups such as gay men (MSM), transvestites and sex workers, instead of focusing on vertical transmission (mother-child) has made some donors and the government less eager to put in much funding.

PROCETSS has received relatively little funds from foreign donors: since 1996 US\$ 300,000 per year from USAID, from the EU US\$ 120,000 and from UNAIDS US\$ 50,000. Much more funding goes into the FP program. In 1998 there was no donor funding specifically for the PROCETSS program.

4.2.4. *MINSA-CLAS*

Since 1994 the government works with local shared administration committees (CLAS), responsible for administering local-level public health facilities and preparation of local health programs. For the CLAS system a separate budget line has been created on the MINSA budget. The part of the MINSA budget that has been spent on the CLAS has increased the last few years, in line with the increase of the number of CLAS in the country (currently 900). In 1995, MINSA expended Nuevo Soles 28 million (US\$ 9.8 million) and Nuevo Soles 27.4 million (US\$ 9.4 million) in 1998. The budget for 1999 and 2000 is 40 million Nuevo Soles (US\$ 13.7 million) and 60 million Nuevo Soles (US\$ 20.6 million) respectively.

4.2.5. *PROMUDEH-Gerencia de promoción de la Niñez y Adolescencia*

The Gerencia de Promoción de la Niñez y Adolescencia (GPNA) is one of the three directorates of PROMUDEH and started their activities in October 1996.

The GPNA endorses the principles of the ICPD. Their mission is to promote and protect the rights of children and adolescents, including reproductive rights.

At central level the GPNA works together with other Ministries (MINSA, MED) and departments in devising programs and projects. GPNA helps to develop programs and projects, but does not execute them. They carry over the design to other Ministries or NGOs (e.g. INPARRES, Manuela Ramos, REDESS de Jóvenes) to implement the projects. The UNFPA, Belgium, UNICEF and the Netherlands have provided funds for specific projects.

La Oficina de Plan de Vida Adolescente is one of GPNA's divisions. It was implemented in 1998. GPNA works through community leaders, youth leaders and other informal opinion-leaders to bring across their message on RH, domestic violence, drug prevention and HIV/AIDS. They take an innovative bottom-up approach in that their services are demand driven. GPNA links up with local initiatives (youth clubs, informal activities) and organizes seminars, plays and other IEC activities. Current programs of this division are:

- Salud Sexual y Reproductiva en las Defensorías Comunes de Niño y Adolescente
- Salud Sexual y Reproductiva en la Red de Líderes Adolescentes

Funding for these two programs in 1999 is estimated at US\$ 58,598 and US\$ 136,797 respectively. For their anti-drug program GPNA has received funds from the Netherlands (US\$ 364,995) through the Comisión de Lucha Contra las Drogas (CONTRADROGAS). This program also has an RH component (IEC on prevention of HIV for adolescent mothers).

4.2.6. *PROMUDEH- Gerencia de la Desarrollo Humano*

The PROMUDEH directorate Gerencia de Desarrollo Humano (GDH) has a coordinating function in relation to the implementation of the national Plan of Population 1998-2002. The GDH serves as the general secretariat of the COORDIPLAN, which is the highest coordinating body of GOP in the population field. The COORDIPLAN devises and monitors the execution of the Population Plan.

Main funding of PROMUDEH comes from UNFPA, USAID, Pathfinder (via USAID), Population Council (via USAID).

4.2.7. *Ministerio de Educación- Programa Nacional de Educación Sexual*

Since 1983 the Peruvian Ministry of Education has undertaken population and sexual education, with support from UNFPA and UNICEF. Between 1990-1995 however, external support was suspended. The Ministry of Education is responsible for the implementation of the National Plan for Sexual Education, initiated in 1996. The program is aimed at providing sexual education to students and teachers, including IEC and capacity building in the areas of family planning, reproductive health, responsible parenthood, health family life, gender and STD/HIV/AIDS. Currently special attention is paid to unwanted pregnancies, domestic violence and child abuse.

The program has a national coverage and includes all levels of the schooling system; it covers all regions and departments of Peru. Between 1996 and 1999 a total of 29,570 educators at primary and secondary were capacitated in family and sexual education; for the period 2000-2002 an additional 40,000 are to be trained. In addition the program aims at sensitizing and informing journalists and other media workers on sexual education.

IEC materials such as teacher guides, folders, video's, posters and pamphlets are produced and distributed. In addition, the program makes use of TV and radio spots tailored to the target population. With UNFPA support MED has made ten radio/TV spots which have been presented at fairs on World Aids Day.

It is a vertical program under the Ministry of Education (MED). At central level the Ministry works with consultants from MINSAs for the development of materials but execution of the program is done by MED. The program has no link with the alphabetization campaigns of PROMUDEH. Currently a national monitoring system is being devised, for all educational levels. Education specialists and coordinators report each semester on activities, number and type of materials distributed, target groups reached etceteras. The information is stored in a database at MED and used for future planning.

The UNFPA has been the main external donor of the program since 1996. The budget for the period 1997-2001 envisaged at total UNFPA contribution of US\$ 1.8 million. The Peruvian governments' contribution was pegged at Nuevo Soles 11.5 million or US\$ 4 million (source: MED). Pathfinder has contributed an additional US\$ 20,000 in 1999, for program monitoring. In 1997 the Ministry of Education spent US\$ 981,000 on the sexual education program and in 1998 US\$ 489,000.

4.2.8. *Instituto Nacional de Estadística y Informática (INEI)*

The national statistical and census office of Peru was established in 1969, and changed its name to *Instituto Nacional de Estadística y Informática (INEI)* in 1990. The INEI is responsible for producing official statistical data on Peru's population; INEI executes the population census and the DHS surveys. The *Dirección Técnica de Demografía y Estudios Sociales* covers reproductive health (DHS) while the *Dirección de Censos y Encuestas* is responsible for the population census.

In 1998 a household survey was conducted (*Encuesta Nacional de Hogares*) with a separate module on RH, FP, perception of SIDA. The results are currently being processed. The next population census is planned for the year 2001.

The ENDES (DHS) surveys were supported by the World Bank with US\$ 1.3 million. Part of this was commissioned to Macro International for technical assistance. The GOP provided 300 million for personnel and infrastructure.

In 1996, US\$ 800,000, in 1997 US\$ 335,451 (Nuevo Soles 892,300) and in 1998 INEI expended US\$ 150,000 (Nuevo Soles 441,091) for its research activities (excluding salaries and equipment).

4.2.9. *ESSALUD*

ESSALUD, formerly the Peruvian institute of Social Security (IPSS), is the employer-based national security institute. ESSALUD covers employees and their dependants in the formal sector. Its establishments are located mainly in urban areas. More than 85 per cent of the total number of insured persons are members of ESSALUD.

ESSALUD has its own health services: they own about one third of the hospitals in the public sector, about 20 per cent of the public health centers and a few health posts. Almost half of the ESSALUD centers are primary care facilities. ESSALUD services around seven million insured persons in Peru, included disabled people on all aspects of reproductive health (including gyneacology, obstetrics, MCH, FP, HIV/AIDS prevention and diagnosis).

Juventud y Salud Program

In 1998 ESSALUD has implemented a peer promotion program in eight regions: the ESSALUD *Juventud y Salud* Program. The program aimed at providing basic RH services. ESSALUD trained professionals and selected and trained youth leaders from among school for promoting reproductive health, whereas also teachers and parents were being involved in the program. Methods used are dance, theater and printed material for promotion. The program is now being expanded to another 22 regions at a national level.

As from January 1999 ESSALUD receives no more external funding. Cooperation with MINSA takes place on the subject of occupational health and with Pathfinder on an adolescent reproductive health program. In family planning the ESSALUD program is vertical; the main method distributed by ESSALUD is the IUD.

In 1998 ESSALUD spent over US\$ 8 million on its programs for family planning, reproductive health and youth (RF database). The total ESSALUD budget in 1999 was Nuevo Soles 2,570 million (US\$ 882 million), of which Nuevo Soles 164 million (US\$ 56,4 million) for prevention programs. A budget of Nuevo Soles 39 million (US\$ 13,4 million) was divided over five reproductive health programs: family planning (33 per cent), gynecological cancers (26 per cent), STDs/AIDS (20 per cent), prenatal care (17 per cent) and the adolescent program (5 per cent).

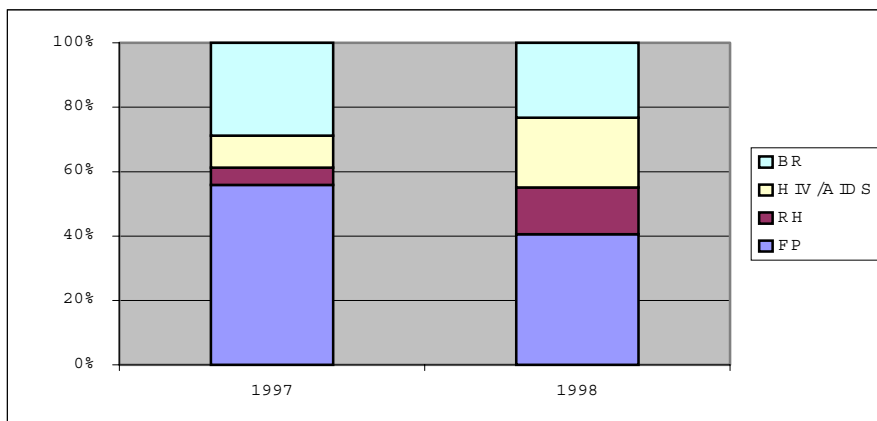
4.3 | Role of national NGOs

The total expenditure of three large Peruvian NGOs (INPPARES, Centro Flora Tristan and Movimiento Manuela Ramos) was US\$ 5.4 million (1997) and US\$ 4.3 million (1998).⁵ As can be seen (Figure 9) most funds were expended on family planning activities, followed by basic research and policy development and HIV/AIDS.

⁵ For 1996 only data from INPPARES are available: the expenditures were US\$ 1 million.

The share of total income from external sources for four Peruvian NGOs working in reproductive health (INPPARES, Centro Flora Tristan, Movimiento Manuela Ramos, Via Libre, APROPO) was 73 per cent for the years 1997/98. However, only INPPARES and APROPO generated own funds of any significance, while the other three were almost wholly dependent on external financing.

Figure 4.5. Expenditures of INPPARES, Centro Flora Tristan and Movimiento Manuela Ramos, by ICPD category, 1997-98 (US\$)



Source: RF database.

Instituto Peruano de Paternidad Responsable (INPPARES)

The IPPF affiliate INPPARES was established in 1976; its predecessor was the *Asociación Peruana de Protección de la Familia* (APPF). The activities of INPPARES are underpinned by the Cairo and Beijing conferences. Their mission is the improvement of the quality of life of Peruvians through the provision of high quality family planning and reproductive health services.

INPPARES currently operates 83 clinics and works through community distribution points and with over 800 trained health promoters. Contraceptives are marketed at low cost through the clinics next to the provision of a whole range of reproductive health services, including HIV/AIDS tests and counseling, pap-smears, obstetrics, gynecology and infertility treatment. Their services have a national coverage. Special family planning brigades provide services to almost half a million people in remote under-served communities in Peru. INPPARES markets drugs and contraceptives and promotes Norplant in collaboration with the Finnish company Leiras Pharmaceuticals. INPPARES also operates a documentation center specialized in family planning and reproductive health. The various current projects pay special attention to high-risk groups, increased coverage and quality improvement of services, HIV/AIDS prevention, unsafe abortion, gender equality and male involvement.

IEC and training is an important component of INPPARES' work: training in reproductive health and HIV/AIDS prevention is provided to adolescents, health workers, teachers, parents and journalists. Their peer-education program trains over 100 youth promoters annually which do out-reach work in schools and in communities. A few times a year, INPPARES organizes so-called open-air health and family planning fairs in shanty towns, in collaboration with other organizations e.g. MINSA and Via Libre. Capacity building workshops have also been organized for the Ministry of Education.

Special attention is paid to adolescents through the INPPARES youth center (*Centro Juvenil "Futuro"*) and a youth program (*Programa de Jóvenes*). These comprise of peer educator training in reproductive health, HIV/AIDS, youth rights and counseling. An integrated project aimed at improving the health, education, employment and social participation of adolescents is implemented in Metropolitan Lima.

INPPARES is involved in advocacy activities aimed at the government, local NGOs and donor organizations. They participate in the *Mesa Tripartita* meetings in the role of advisor. Other advocacy activities are aimed at community groups, local governments, universities and lawyers.

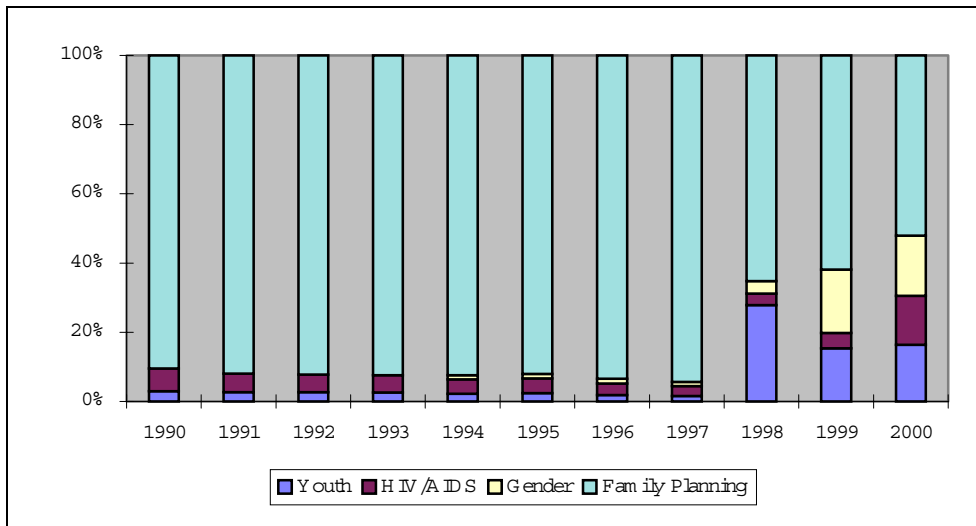
INPPARES works together with the government, NGOs and the private sector.

Some of the most conspicuous INPPARES projects are:

- IPPF Vision 2000 project (focus on unmet need, abortion, women's empowerment, reproductive/sexual health, youth and quality of care);
- *Acción Comunitaria en Planificación Familiar*, aimed improving quality and coverage of RH services in Metropolitan Lima, with support from USAID/PRISMA;
- IEC project on RH/ sexual health for youth, under contract of MED;
- *Proyecto Transición*, aimed at establishing quality, integrated RH services in rural areas;
- *Centro Juvenil Futuro*, IEC for youth and adolescents;
- *Programa Nacional de Capacitación a Docentes en Educación Sexual*, in collaboration with the Ministry of Education;
- *Convenios con gobiernos locales*, aimed at strengthening FP services at local level and promoting community participation, supported by PATHFINDER;
- *Programas radiales y clases radiofónicas*, IEC on FP and AIDS, supported by DFID;
- Pilot street youth project in Lima on FP/HIV/AIDS, partly funded by Terre des Hommes;
- Pilot domestic violence refuge center in Lima.

The INPPARES clinics are 95 per cent self-sustainable and have their own budgets. The central INPPARES office only provides technical assistance. INPPARES' total income has steadily increased from around US\$ 1.4 million in 1990 to an estimated US\$ 3.2 million in 1999. Between 1990 and 1997 external funding increased from around US\$ 948,000 to US\$ 2.1 million, after which it leveled off to US\$ one million in 1998. The self-generated income has remained stable at about one third of total income in this period.

Figure 4.6. INPPARES estimated expenditure in US\$ by activity, 1990-2000



Note: 1990 and 2000 data provisional

The main external donors of INPPARES in the past have been IPPF, AVSC, PATHFINDER, the Hewlett Foundation, Development Associates and the Population Council. After 1995, DFID, UNFPA, USAID (currently phasing out), European Union and the Netherlands became donors. For their activities to promote safe abortion, INPPARES received small grants from IPAS and the Bergstrom Foundation. Murcia España supports a center for adolescent mothers.

The larger part of INPPARES' funds was expended on family planning in the period 1990-1999 (Figure 4.6). However, the share of family planning services will decrease in the future in favor of projects in the field of youth and adolescents, HIV/AIDS prevention and gender.

APROPO

APROPO (Advocacy for Population Programs), a non-profit NGO was established in 1983 by a number of Peruvian entrepreneurs. APROPO develops and implements projects in the field of family planning, reproductive health and sexuality with the objective to improve the quality of life for men and women equally.

This NGOs' main activity has been the promotion of family planning and the social marketing of contraceptives. APROPO is a pioneer in the field of social

marketing and has promoted condoms since 1984. Next to its own brands (Piel condom and APRO-T IUD), that were introduced with success on the commercial market, other contraceptives such as Depo-Provera and Microgynon are promoted. Promotion is done through pamphlets, mass media messages, video's and through more popular means such as street theatre and comics. In 1998 a nationwide contest on sexuality and reproductive health was organized, with support from PROMUDEH and the UNFPA. In addition, APROPO operates a telephone counseling hot-line (24,000 calls in 1998). APROPO is involved in IEC activities and training on family planning, reproductive health and HIV/AIDS for adolescents and to community leaders and health service providers. Their IEC materials are adjusted to the different ethnic groups in Peru and translated into several native languages (e.g. Quechua).

APROPO aims at building partnerships with all stakeholders in health, i.e. the government, NGOs and the private sector. They have worked together with MINSA, PROMUDEH, the Ministry of Education and with private sector companies (e.g. Shering, Medifarma, Peruvian Telcom).

APROPO currently provides technical assistance to the Social Program of the Peruvian mining company ANTAMINA in the department of Ancash in northern Peru. This integrated development project started in 1998 and is aimed at improving the environment, nutrition, education and health of the poor people in the mining area.

Externally funded projects with involvement of APROPO in the past are:

- Social marketing of Contraceptives, Phase I and II, funding of US\$ 6.9 million by USAID;
- Social marketing and CBD project, funded by USAID/SOMARC, PATHFINDER, Population Council, budget of US\$ 31,000;
- Studies in family planning in corporations, US\$ 89,000 by USAID;
- Mother-child survival and family planning project in Peruvian mines (TIPPS, John Snow), budget US\$ 32,000;
- 22 projects on responsible parenthood, financed by Family Planning Assistance, US\$ 78,000.

The major donors have been USAID/SOMARC (social marketing project), the Netherlands (printed media IEC project), DFID (telephone hotline). Next to donations, APROPO's income is generated through member contributions and the sale of social marketing products. Total income was around three-quarters of a million Nuevo Soles (US\$ 250,000) in 1997 and 1988.

VIA LIBRE

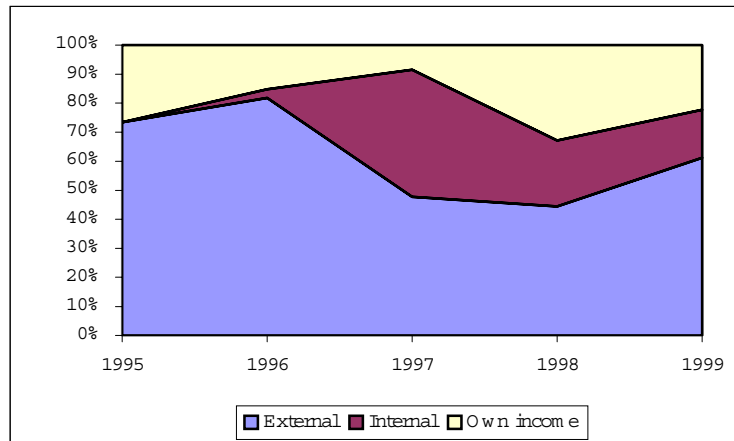
The NGO Via Libre started its activities in 1990 and works with volunteers. The objective is to develop STD/HIV/AIDS primary prevention strategies, to improve the quality of life of people living with HIV/AIDS by providing comprehensive health care and promoting their rights and finally to train health providers in STD/HIV/AIDS. Via Libre has built up considerable expertise in the field of STD/HIV/AIDS prevention and treatment. Furthermore, Via Libre has played an important role in the organization of the current national STD and AIDS Control Program under MINSAP/PROCETSS.

Via Libre has its own clinic, dentist and documentation center in Lima. Via Libre provides low cost services, condoms and counseling to people living with AIDS. In principle however, Via Libre charges clients according to their income, the poorest get free counseling and drugs. Via Libre develops its own IEC material including handbooks, leaflets, posters, video's and radio spots. The Via Libre Hotline is operational since 1996. Via Libre also conducts epidemiological surveys and has organized HIV/AIDS counseling training workshops (some under contract of PROCETSS).

Target groups for IEC and social marketing of condoms are sex workers, homosexuals, street youth and adolescents. They aim at improving the target groups self esteem and to avoid risky behavior. Currently Via Libre has 75 health promoters in five districts in Lima. At the Via Libre center in Lima there is about 25 staff.

Via Libre has received some financial support from the government (MINSAP; Lima health department) through the years. Most funds however are from foreign donors such as MEMISA, PAHO, University of Washington, UNAIDS, WHO and USAID. The Dutch NGO HIVOS has remained an important donor since 1991 (about US\$ 65,000 per annum between 1991-1999). Total funding between 1995 and 1999 fluctuated from US\$ 180,000 in 1995 to a high 766,000 in 1997. The share of self-generated funds fluctuated through the years with a low 9 per cent in 1997 to a high 33 per cent in 1998 (Figure 4.7).

Figure 4.7. Source of funding of Via Libre, 1995-1999



Centro de Mujer Peruana Flora Tristan

The NGO *Flora Tristan* has been active since 1979 in the field of reproductive and sexual health, women's rights and support to rural women. Centro Flora Tristan provides IEC services and expertise for institutional strengthening and capacity building in reproductive health. One of Flora Tristan's principal lines of action is the advocacy, IEC and training aimed at the improvement of reproductive health services, women's rights, safe abortion and the eradication of domestic violence. In these activities Centro Flora Tristan co-operates with PROMUDEH, the Congress' Commission for women, the National Police of Peru, the judiciary and municipalities.

At present, Flora Tristan executes a pilot health project in Lima's largest district San Juan de Lurigancho. It is aimed at the improvement of quality of services through health promoters. The pilot is used as a model by MINSA to implement similar health promotion centers in the regions. Workshops are realized in collaboration with NGOs, MINSA and the district municipalities. Other activities are advocacy, workshops on reproductive health, capacity building, training of internees from other regional NGOs, research and sensitization of media workers on women's (RH) rights and work on the politico-cultural barriers in RH. Flora Tristan operates a documentation center in Lima specialized on reproductive health, domestic violence, women's rights and development. A master degree course on gender at the San Marco University is set up in co-operation with the Centro Flora Tristan.

Flora Tristan is member of the *Consortio Mujer*: a network of NGOs working in RH, such as Cendoc Mujer, CESIP, Manuela Ramos, Centro Amauta-Cusco, Centro Ideas-Piura and CEPCO-Tarapoto. They have published the report *Calidad de Atención en la Salud Reproductiva: una mirada desde la ciudadana femenina*, Lima, 1998. Centro Flora Tristan is one of the Peruvian NGOs participating in the *Mesa Tripartita* meetings for the monitoring of the ICPD PoA.

Centro Flora Tristan does not receive funding from the Peruvian government. The organization is donor dependent as the self-generated funds are negligible (2-3 per cent). Total funds between 1995 and 1998 fluctuated between US\$ 2.2 million (1995) and US\$ 900,000 (1998). The major international donors in the past were the Dutch and the German protestant organization *Evangelische Zentralstelle für Entwicklungshilfe* (EZE). Other funds have come from international NGOs and foundations (e.g. SNV, ICCO, Ford Foundation, MacArthur Foundation, Oxfam), donor countries (USAID, Sweden, Canada, Germany, EU) and multilateral organizations (UNFPA, UNIFEM, UNICEF).

Movimiento Manuela Ramos (MMR)

Founded in 1978, Manuela Ramos' staff consists of 100 persons in Lima and 70 in the regions. The main purpose of the institution is to help foster the reproductive and sexual health of women as well as their sexual and reproductive rights. USAID is the main donor of MMR. Comparatively little funds are received from UNFPA, OXFAM, The International Women's Health Coalition, FORD and PAHO. Since its inception, MMR has made no major changes in policy or areas of attention. However, since 1998, they give more attention to male involvement in RH and FP.

MMR work especially with 4 lines of actions: 1) Investigation and research (strengthened since 1990), 2) Quality of medical services, 3) Rights of Women users of health facilities and 4) Advocacy

The main programs of MMR are:

ReproSalud (August 1995- September 2000) was implemented in 1995 to increase the use of FP and selected RH services in 8 of the poorest areas in Peru: Ayacucho, Huaraz, Piura, Trujillo, Huancavelica, Puno, Pucallpa, Tarapoto and Lima. At the same time *ReproSalud* seeks to improve the RH status of women in the target areas. Working through selected community based organizations,

MMR, with the cooperation of Alternativa (NGO), aims at IEC, auto-diagnosis of women's RH needs and at developing strategies to resolve the prioritized RH problems. ReproSalud is financed by USAID. MMR received US\$ one million in 1996; US\$ 1,75 million in 1997 and almost US\$ 3 million in 1998. Currently, MMR is negotiating an extension of the program.

Pamplona Alta. The program concentrates on promoting women's RH and on FP in Pamplona Alta, a peri-urban area at the south of Lima. MMR trains health promoters and aims at capacity building, IEC in RH and FP counseling, whereas distribution of free contraceptives (injectables, oral and IUDs) is provided through A.B. Prisma (NGO).

Furthermore, MMR, organizes health campaigns and gives limited support to income-generating and credit activities of women that are closely linked to RH. Other areas of attention are domestic violence, advocacy and IEC on legal rights, prevention of cervical cancer (supported by MINSA), male involvement (responsible parenthood), prenatal care and safe delivery, RTI's, and IEC on reproductive health, family planning and STDs for youth.

Red Nacional de Educación, Salud Sexual y Desarrollo para Jóvenes (REDESS Jóvenes)

REDESS Jóvenes is a professional network established in 1994, which received initial funding from the Ford Foundation for institutional strengthening in 1995. The network has nineteen voluntary members from public, private and donor institutions, with a core staff of seven people. Their mission is the promoting of policies, strategies and activities aimed at improving the level of access, quality and equity in education and health services for young people in Peru. This is done through capacity building, IEC, advocacy and institutional strengthening in the field of reproductive health and gender. The REDESS Jóvenes professionals assist partners to identify reproductive health problems, prioritize and formulate proposals.

Basically, REDESS Jóvenes help set up pilot projects to be taken over by government agencies. They foster co-ordination between NGOs, government agencies and international organizations to increase efficiency and avoid duplication of projects. Currently, REDESS Jóvenes co-operates with APROPO, INPARRES, CESIP and the Peruvian Institution for Sexual Education. A plan for the establishment of a large network of over forty NGOs, government agencies and international donors has been prepared.

Specific REDESS Jóvenes projects include:

- the PATHFINDER/USAID FOCUS project aimed at IEC, capacity building and advocacy;
- IEC project on HIV/AIDS, done in conjunction with PROCETSS;
- development of guides on sexual education with the Ministry of Education;
- IEC on family planning, teenage pregnancy, drug abuse and gender based violence and AIDS for school youth.

With funding from USAID-FOCUS in 1998, the REDESS Jóvenes developed a Work Plan for 1999-2004, which outlines the objectives, strategies and sub-projects for the near future (REDESS Jóvenes, 1999). The aim is to establish an overall inter-institutional and inter-sectoral consortium, based on tripartite commissions, each responsible for preparing specific sub-projects. These sub-projects are aimed at: 1) strengthening IEC on reproductive health for youth in public institutions (MINSA, PROMUDEH); 2) capacity building, e.g. in the context of the sexual education program of the Ministry of Education; 3) strengthening integrated health services for youth in private and public institutions; 4) promoting and defending sexual rights through advocacy and sensitization, and 5) research on reproductive health. The commissions are envisaged to include representatives from the public and private sector, next to donor organizations, e.g. MINSA, PROMUDEH, Ministry of Education, INEI, INPPARES, Flora Tristan, APROPO, USAID, DFID, CARE-Peru and UNFPA.

REDESS Jóvenes' self generated income is insignificant; their funds come mainly from the Ford Foundation, USAID and contract income from the Peruvian government.

Red Nacional de Promoción de la Mujer (RNPM)

The Red Mujer is an advocacy network for the promotion of women's rights, including those pertaining to reproductive health, formally established in March 1990. Initially a feminist group, coming out of a cooperation between among others the Peruvian NGOs Flora Tristan, Movimiento Manuela Ramos, CESIP, since a few years it has become a more plural organization. In 1999, RED Mujer consisted of 800 representatives of a myriad of civil society organizations and government agencies, local governments, municipalities, labor unions, women's self help groups, Catholic church groups and academics. The local groups and regional committees identify, monitor and evaluate policies and women's needs,

which are reported to the Red Mujer's general assembly, which in its turn formulates an advocacy strategy.

Their current mission is to increase the role of civil society in women's affairs and rights and mobilize and sensitize policy makers to gender and women's rights. RED Mujer has provided valuable input to the Action Plan for the Development of Women (*Plan de Acción de Desarrollo de Mujer, 1990-1995 and 1996-2000*) of PROMUDEH and has also worked with the Ministry of Justice (*Oficina de Derechos de la Mujer*). Their principal aim is to foster the implementation of the Women's Plan of Action at all levels of society. In particular the RED Mujer advocacy activities concern women's physical and mental health, access to services and education, domestic violence, sexual abuse and women's image in mass media.

RED Mujer participated in the Beijing Platform, Cairo +5 and the annual *Mesa Tripartita* meetings in Lima. Their network has been expanded to women's networks in Canada and Guatemala. The RED Mujer is funded by CIDA, the UNFPA, the Ford Foundation, the Netherlands (gender project, terminated in December 1999), USAID-POLICY project in 1998 (advocacy), the European Union (project women and civil rights), CUSO-Canada and PAHO. Some support comes from Boston University for activities for girls in rural areas.

Funding for RED Mujer has come from CIDA (Canada), UNFPA, the Netherlands Embassy (Gender program, terminated in 1999), Ford Foundation and through the USAID-POLICY project in 1998 (for developing advocacy strategy). RED Mujer received voluntary donations to the amount of US\$ 2.4 million in 1997 and US\$ 2 million in 1998.

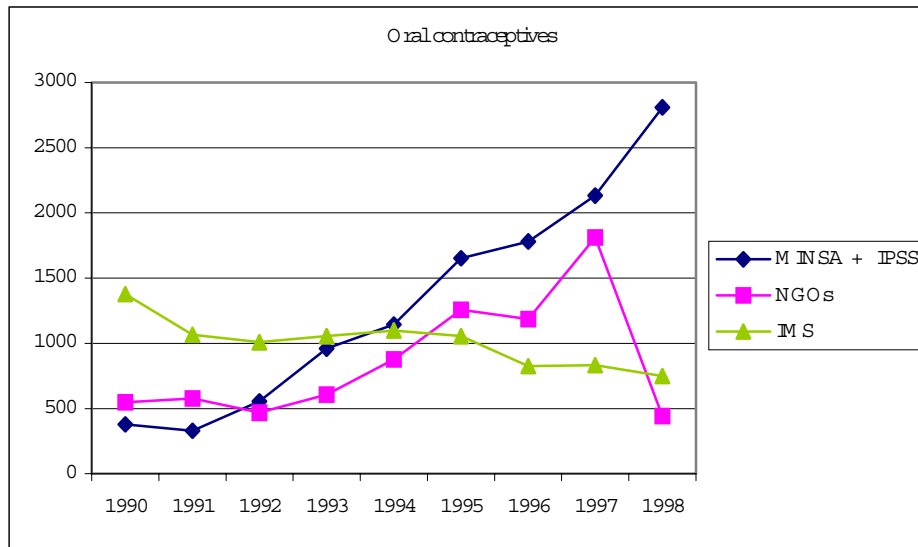
4.4 | Role of Private Sector

Measuring the contribution of Peru's private sector to reproductive health is difficult, due to problems of categorization and inadequate budget lines. The private sector does have a large role to play, be it in funding NGO projects in reproductive health and through the delivery of services. The Peruvian health services system consists of two sub-sectors; the public sector comprises the Ministry of Health (MINSa), ESSALUD and the health units of the Armed Forces and Police (PAHO 1998).

MINSA caters to the poor population without public (ESSALUD) or private insurance, with services in marginal urban and rural areas. ESSALUD is for the formal sector workers, mainly in the urban areas and the Army and Police have their own services for personnel and their families. The private sector comprises of a myriad of clinics, private physicians and some NGOs, mainly in the large urban centers. In 1996, the public sector operated 87 per cent of a total of 7325 establishments. Almost a quarter of the population had health insurance mainly via company social security schemes (ESSALUD and through 14 insurance companies). In terms of the financing of health care services, most funds come from the government (38 per cent in 1996), which are channeled through MINSA and the regional health departments. The households (32 per cent) mainly expend through pharmacies and private clinics, while the resources coming from the companies (29 per cent) go through ESSALUD and private sector services. External funding represents a mere 1 per cent of total health care services.

In the provision of contraceptives, the private sector has been important. In 1985, three quarters of users acquired their contraceptives from the private sector (Bogue *et al.*, 1986). The role of the private sector has declined since then. In 1996 only 27 per cent of users obtained modern contraceptives from the private sector outlets. According to the DHS the commercial sector market share was 38 per cent in 1991 and 25 per cent in 1996. The market share for the different contraceptives in 1996 was as follows: condoms 69 per cent, oral pills (33 per cent), IUD (14 per cent), injectables (11 per cent) and female sterilization (17 per cent) (DHS 1996, p. 72).

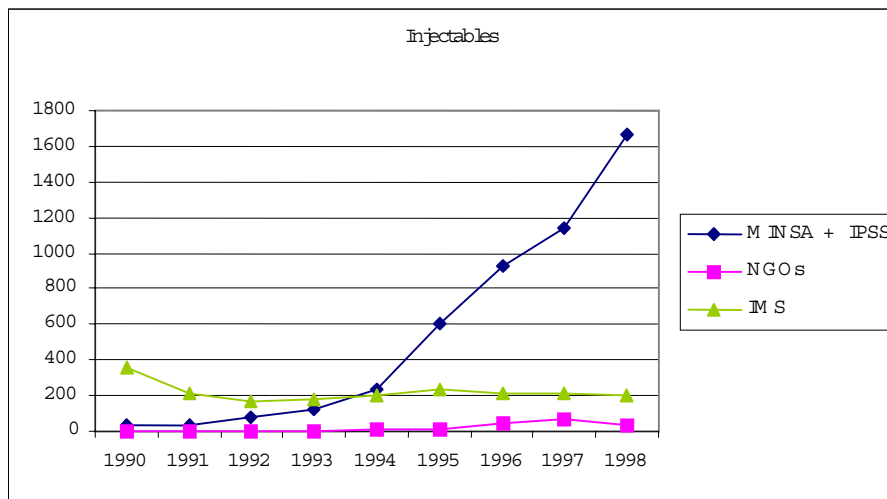
Figure 4.8. Peru: marketing of oral contraceptives by sector, 1990-1998



Source: PRISMA, IMS.

Note: IPSS (Instituto Peruano de Seguro Social), presently ESSALUD.

Figure 4.9. Peru: marketing of injectables by sector, 1990-1998



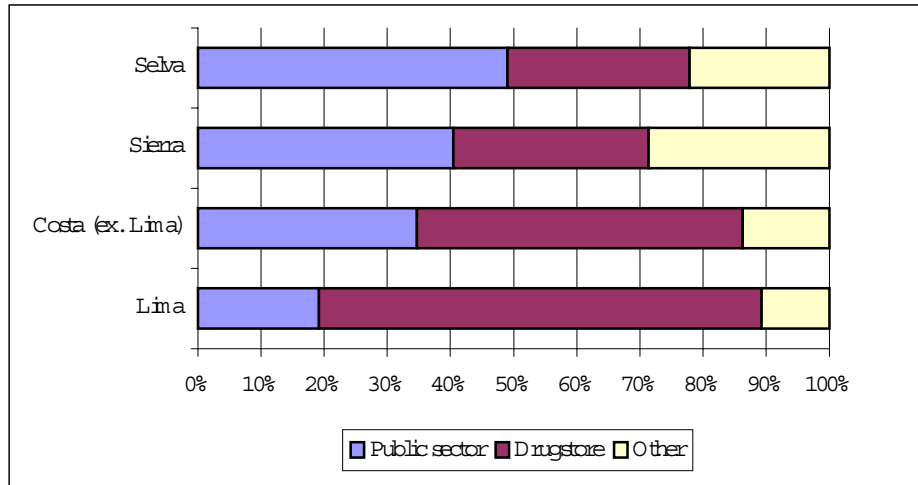
Source: PRISMA, IMS, Shering Inc., Peru

The private sector still makes a significant contribution in Peru however, particularly in the provision of contraceptives. For example, the private company Shering Inc., one of the market leaders in Latin America, has been active in social marketing of contraceptives in Peru for several years. However, since the Peruvian government is providing free contraceptives through the National Family Planning program, the share of the private sector and NGOs is diminishing. Due to this policy, the private and NGO sectors are priced out of the market as more users of modern contraceptives turn to free contraceptives at the governmental outlets. As a result Shering Inc. has discontinued its social marketing partnerships with Peruvian NGOs such as APROPO and INPARRES. Shering is currently negotiating the marketing of the new contraceptive CycloProvera, in partnership with MINSA.

When considering the trend in marketing of oral contraceptives and injectables (Figure 4.8 and Figure 4.9), the above noted trend is confirmed. The number of oral contraceptives and injectables marketed through the public sector superceded that of the other sectors since 1994. The trend for oral contraceptives is particularly marked since 1997, indicating that the NGOs are pushed out of the market. In the case of injectables, the trend is even more marked. The public sector has always been an important provider of these contraceptives.

However, it is important to note that the availability and provision of contraceptives varies by region, as is shown by the following figure. Although the private sector has an important role to play in the provision of condoms in all regions of the country, it is clear that the more isolated mountain and Amazon regions of Peru are more dependent on the public sector.

It remains to be seen whether the public sector will be able to sustain the provision of free contraceptives as the program will become very costly. It has been noted that one option to reduce costs is to narrow down the provision to injectables, but this is not agreeable to the principle of informed choice and will increase infertility problems of young women.

Figure 4.10. Source of condoms by region, Peru 1996

Note: "Other" includes private medical practitioners and unknown.

Source: INEI, ENDES 1996.

5. Concluding remarks

5.1 | ICPD and the Peruvian population program

Peru has made progress in the integration of population issues in its overall development policies and programs. The government has endorsed the Cairo and Beijing programs of actions and has seriously been working towards realizing the goals. Major developments have been the promulgation of the national population programs, the emergency plan for maternal mortality, health sector reform, the establishment of PROMUDEH, COORDIPLAN and the Tripartite Commission. However, despite the fact that reproductive health has received attention during the last decade, family planning has still remained a dominant theme, which has translated in a large share of total government funding to this theme. Major problems have persisted, in particular high maternal mortality rates, unsafe abortions and major discrepancies in access and quality of health services between rural and urban a reason the one hand and between the different regions in Peru.

Programs are still vertical in nature and not fully integrated, although the government has embarked on sectoral reform and decentralization. The system of budgeting and financing is quite intricate and is under reform, which makes the in-country tracking our financial resource flows for population activities problematic.

5.2 | Implications for data collection on resource flows

A number of points in connection with tracking resource flows for population activities should be mentioned here:

- Budgets and overviews of expenditure at central (ministerial) level should be supplemented by those from the regional health departments
- Costs for salaries of health personnel at departmental level are not in the MINSA budget, and therefore should be collected separately.
- A comprehensive overview of resource flows for population programs in Peru should include the specific programs of the Army and Police.
- Considering its importance in the provision of health services, specific attention is needed for the private sector.
- In general, considering the fact that regular reporting on public sector expenditures is still deficient, it will not always be possible to collect expenditure data or even allocations.

Next to continuing collecting information through mail enquiries to the main NGOs and Government Departments involved in reproductive health we need to collect information at the central and departmental levels in order to arrive at a more comprehensive picture of resource flows. In addition, including the private sector in the survey, however difficult, is necessary if one aims at more accurate estimation of resource flows for population and reproductive health in Peru.

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Annex

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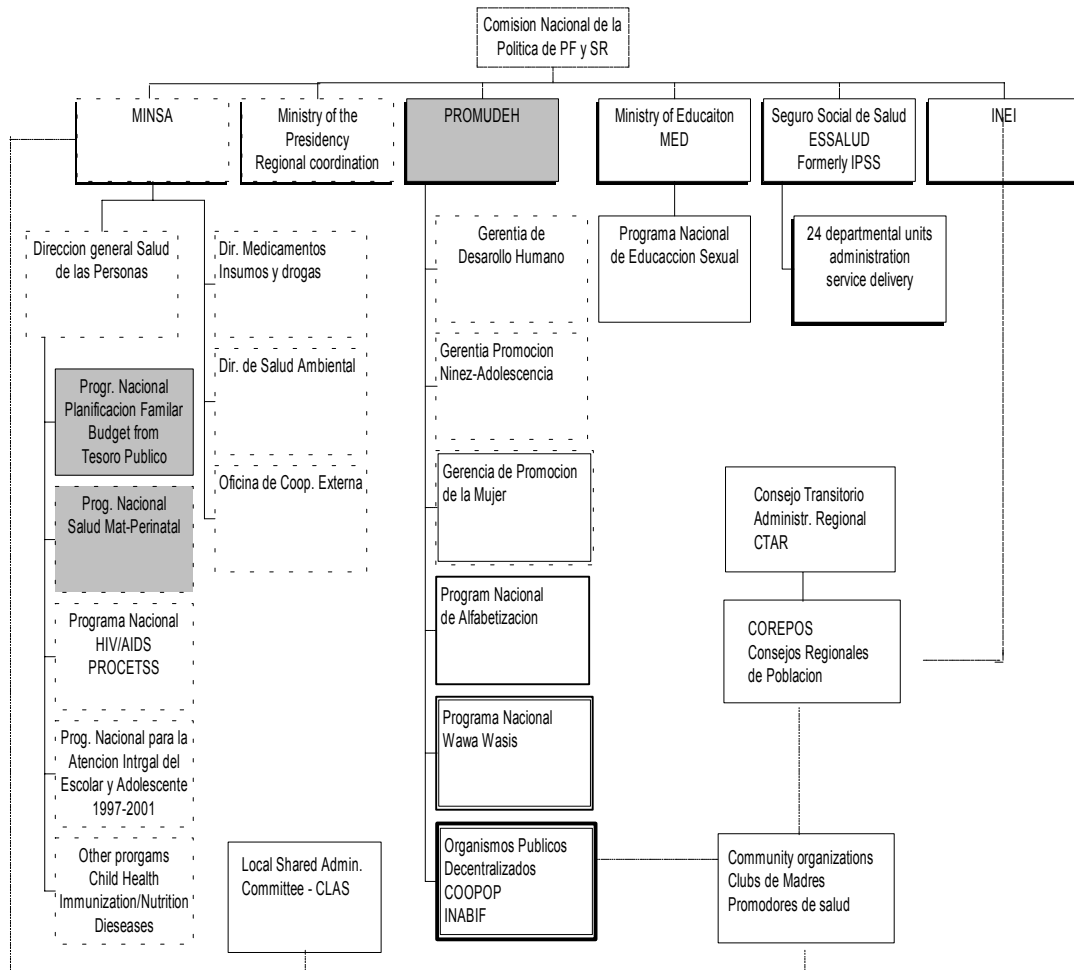
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Annex 2: Organogram of organizations and RH programs



Annex 3: National Plan of Population, 1998-2002

Objective	Aim	Responsible agency	
Strengthen incorporation of pop. in planning and programs on national regional and local level	1	Pop. Growth and distribution in planning and strategies	PRES
	2	Incorporate population in development and poverty plans	PRES
	3	Sensitization of parlement and public sector workers/IEC	PROMUDEH
	4	Study and analyse population on all administrative levels	INEI
Improve sexual and RH health for men and women, population in poverty, safeguard freedom of choice in FP/RH	1	Match fertility level with demand of population	MINSA, IPSS, PROMUDEH
	2	Provision of RH services, including cervical cancers using IEC with 100% urban and 80% rural coverage	MINSA, IPSS, PROMUDEH, MED
	3	Increase coverage of RH services by reducing unmet need for FP (12%)	MINSA, IPSS
	4	Reduction of MMR by 50% from 1996	MINSA, IPSS
	5	Improve quality of RH services	MINSA, IPSS
	6	Promote male involvement in FP to 10%	MINSA, IPSS, ROMUDEH
Promotion of gender equity, respect and responsibility in gender relations	1	Diminish differences in health services, increase male role in parenthood, FP	MINSA, IPSS, MED
	2	Promotion of parental participation in maternal-perinatal health, prenatal control with 75% of qualified attention for pregnant women, esp. for poor areas	MINSA, PROMUDEH
Initiate IEC for adolescents on family life, RH, unwanted pregnancy, equity	1	IEC services in 66% of health centers	MINSA
	2	Reduce unwanted pregnancy by 25%	MINSA, PROMUDEH, MED
	3	IEC on RH, STD/AIDS on 90% of schools	MINSA, PROMUDEH, MED
	4	Increase coverage National Program of Sexual Education to 100% of 2nd public schools, 50% primary schools, and 40% of higher institutions	MED
Improve quality of life via integration of population in strategies of sustainable development, regional and local	1	IEC on population in major cities	PROMUDEH, PRES
	2	Capacity building and integration of population in decentralized institutions	PRES, INEI
	3	Formulate technical criteria to diminish geographical differences in quality of life	PRES, CONAM
	4	Develop programs to help reduce the negative impact of demographic/economic processes on environment in Amazonia, Piura and Cuzco	PRES, CONAM

